PAYMENTS TO CERTAIN MEDICARE FEE-FOR-SERVICE PROVIDERS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

U.S. GOVERNMENT PRINTING OFFICE

47–174 WASHINGTON : 2009

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CONTENTS

PAYMENTS TO CERTAIN MEDICARE FEE-FOR-SERVICE PROVIDERS

TUESDAY, MAY 15, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:05 p.m., in Room 1102, Longworth House Office Building, the Honorable Fortney Pete Stark (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 15, 2007
HL–11

CONTACT: (202) 225–1721

Chairman Stark Announces a Hearing on Payments to Certain Medicare Fee-for-Service Providers

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on payments to hospitals, home health agencies, and skilled nursing facilities. **The hearing will take place at 2:00 p.m. on Tuesday, May 15, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The vast majority of Medicare beneficiaries—nearly 82 percent in 2007—receive care within the traditional fee-for-service (FFS) program, rather than in a private plan under Medicare Advantage. Payments under FFS are projected to constitute 71 percent of overall Medicare benefits spending in 2007. Payments to FFS providers are typically based on a prospective payment system or a fee schedule. The goal of various Medicare FFS payment systems is to cover the costs that reasonably efficient providers would incur in furnishing high quality care.

In announcing this hearing, Chairman Stark said: **"It has been far too long since our Committee has taken a thoughtful look at the payment systems for fee-for-service providers. Let's not forget that the vast majority of Medicare beneficiaries and payments are under the fee-for-service system. As stewards of the Medicare program, we must take seriously our oversight responsibilities to ensure that Medicare pays efficiently and appropriately for quality care."**

FOCUS OF THE HEARING:

The hearing will focus on issues related to payment accuracy and legislative and regulatory payment refinements for the Medicare inpatient hospital prospective payment system, outpatient hospital prospective payment system, home health, long-term care hospital, inpatient rehabilitation facility, and skilled nursing facility payment systems.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled,

"*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, May 29, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, and telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. If you could, just take a seat. I'm pleased to announce Herb Kuhn and Mark Miller are here.

Herb Kuhn is the acting deputy administrator of the Centers for Medicare and Medicaid Services. During his tenure he has been a key leader in the movement to transform CMS from a passive player of health services to an active purchaser of quality health care. He is a nationally recognized expert on value-based purchasing and payment policy.

Mark Miller is the executive director of the Medicare Payment Advisory Commission, a nonpartisan Federal agency that advises the U.S. Congress on Medicare payment, quality and access issues. With more than 19 years of health policy experience, Dr. Miller has held several important policy, research and management positions in health care. Dr. Miller served as assistant director of health and human resources of the Congressional Budget Office. Prior to CBO,

Dr. Miller was the deputy director of health plans at the Centers for Medicare and Medicaid Service, formerly the Health Care Financing Administration. Before CMS, Dr. Miller was the Health Financing Branch Chief at the Office of Management and Budget, prior to joining OMB. Dr. Miller was a senior research associate at the Urban Institute.

This program is to ensure that Medicare is an efficient purchaser of care in both the traditional fee-for-service program and in the Medicare Advantage program.

As I've said repeatedly, this year no program or payment system, no matter how big or small, should not be reviewed. Everything is on the table in terms of refinement, oversight and adjustment. Medicare inpatient hospital services are the largest portion of our spending, $106 billion in '06, and CMS has recently proposed a regulation that would move forward on MedPAC's recommendation to modify payments based on severity.

I look forward to hearing the details of CMS's proposal and the hospital industry's reaction. While adjustments to DRGs along these lines are overdue, I understand that other parts of that regulation may be problematic for some providers. We'll return to that issue in a minute.

In '06 Medicare spent $43 billion on care provided by post-acute providers. That included skilled nursing facilities, home health agencies, inpatient rehab facilities, long-term care hospitals. These providers are important in ensuring the health of our seniors and people with disabilities, however the question we have to constantly ask is whether we're providing the right care to the right beneficiary in the right setting at the right price.

There is a dramatic variation in the costs of care, often with little or no evidence that outcomes are better in more costly settings. The guiding tenet for Medicare should be that the site of care not be dictated by financial incentives but rather by what's best for the patient. The further challenge for Medicare is that the four post-acute settings, skilled nursing, home health agencies, inpatient rehab facilities and long-term care hospitals, act as individual compartments or silos and don't function as part of an integrated system.

MedPAC and others have highlighted the need for a post-acute assessment tool that guides placement decisions based on the resource needs of the patient regardless of the setting. I hope CMS is making progress in developing a congressionally mandated demonstration project on this issue and that we hear more about that today.

CMS has put forth proposals or is implementing various regulations that attempt to better align payment incentives and ensure payment accuracy. I look forward to hearing CMS testimony on these regulations, however we are hearing from the industry that many of these regulations, particularly the inpatient hospital regulations, are nothing but backdoor attempts to circumvent Congress and cut spending.

I'm loath to intervene in the nuts and bolts of regulations. I usually think that level of detail is best left to the experts like Mr. Kuhn. I recognize that the program needs to make changes to respond to provider behavior. However a lot of fair questions could

be asked about how this behavior was estimated in reaction to the inpatient hospital regulation and the magnitude of payment reductions caused by the adjustment.

Lastly, it boggles my mind that the hospital and post-acute care providers would stand by silently while we continue to overpay Medicare Advantage plans. We learned from the CMS chief actuary a few weeks ago that overpayments to Medicare advantage plans shorten the life of the Part A trust fund by 2 years. That's 2 years off of the life of this trust fund where we get the money to pay the inpatient hospital services and most post-acute care.

Now the program is not in crisis. We have always done what we needed in the past to protect Medicare, and I hope we'll continue to do that. That's one of the reasons we're having today's hearings.

It's important to note that these overpayments directly and negatively affect Medicare's financial outlook. Last I looked it's not as if the plans are treating the hospitals, skilled nursing facilities, or home health agencies very well. In fact, I gather payments from the plans often fall short of Medicare's payment rate under fee-for-service.

I hope that the providers who are here today recognize this tension and will work with us to protect Medicare and ensure its continued strength.

Do you think you can add to that or top it, Mr. Camp?

Mr. CAMP. I think I can, actually. Thank you, Mr. Chairman. Thank you all for coming.

As the Committee seeks to improve the Medicare system we need to examine how the program pays for both hospital and post-acute treatments. Medicare currently allows its beneficiaries, as the Chairman mentioned, to receive care in four different post-acute settings, long-term acute hospitals, inpatient rehabilitation facilities, skilled nursing facilities and in the patient's home.

Medicare payments are seemingly based more on the sign on the front of the facility than on the care provided. These differences in payments have a real impact on Medicare's costs. According to MedPAC a hip or knee replacement patient currently costs Medicare $3,400 more in an inpatient rehab facility than at a skilled nursing facility.

The lack of quality and outcome data make it impossible to compare the two settings. Frankly we don't know whether patients are being treated in the most appropriate setting. The separate payment systems and different assessment tools have resulted in a fragmented post-acute care system and, as the Chairman said, silos of care, potentially resulting in patients receiving treatment at higher intensity than necessary, driving up the cost of the program to taxpayers.

In the Deficit Reduction Act, Congress instructed CMS to develop a demonstration program that would use a common patient assessment tool to better compare the different post-acute care sites. I look forward to hearing what progress has been made in implementing this important project.

I'd also like to say that I'm deeply concerned about CMS's continued expansion of the 25 percent rule to freestanding and grandfathered LTCHs. In 2004, I wrote CMS saying this policy was misguided. I believe then, as I do now, that MedPAC's call for patient

admission criteria is the way to go. Admission should be based on clinical criteria not arbitrary quotas. Simple statistics are denying beneficiaries care at the appropriate facilities, adding unnecessary hurtles to getting care they deserve.

We will hear about a proposal to modify Medicare payments to hospitals. Recently CMS proposed to make significant refinements to the payment system for inpatient services, which would adjust payments to account for sicker, more expensive patients. I've already heard concerns about how CMS has attempted to anticipate changes in hospitals' coding practices under the rule, and I look forward to examining how to best ensure payment accuracy without limiting beneficiary access to important patient services.

I thank the Chairman for this hearing, and I yield back the balance of my time.

Chairman STARK. Thank you, and now let's hear from our first panel.

Mr. Kuhn, would you like to lead off and enlighten us in any manner you're comfortable?

STATEMENT OF HERB KUHN,
ACTING DEPUTY ADMINISTRATOR,
CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. KUHN. Chairman Stark, Mr. Camp, distinguished Members of the Subcommittee, thank you for inviting me here today to discuss Medicare's reimbursement systems and payment updates for acute and post-acute care providers.

The Centers for Medicare and Medicaid Services looks forward to working with Congress in the coming year to further reform Medicare's fee-for-service payment systems and to make strides toward our shared goal of delivering the highest quality of care to people with Medicare.

As the Administration's fiscal year 2008 budget proposals and recent rule-making demonstrate, CMS is committed to ensuring that Medicare providers are paid appropriately and accurately for services furnished to beneficiaries.

In turn, beneficiaries are entitled to and deserving of access to high quality care in the most appropriate setting. We firmly believe that the continued improvement and refinement of Medicare's payment systems with the aim of making the delivery of quality care more efficient will bring us closer to achieving these interrelated goals.

The proposed rule to update hospital inpatient reimbursement in the coming fiscal year is estimated to increase payments to more than 3,500 acute care hospitals by $3.3 billion. CMS is embarking on a third year of refinements to inpatient prospective payment system based on recommendations from the Medicare Payment Advisory Commission. We propose to adopt a severity diagnosis related group system to better recognize severity of illness and the cost of treating Medicare patients.

But increasing the number of DRGs from 538 to 745 we will improve the accuracy of Medicare payments. This follows 2 years of incremental severity adjustments and last year's movement from charge-based to cost-based weights. Consistent with the law, the severity adjustments would be implemented in a budget neutral

manner, neither increasing nor decreasing overall Medicare spending. This step was taken to account for improvements in hospital coding.

That hospitals would code more accurately under such circumstances is a sound and legitimate response supported by research dating back more than $20. Appropriately however, payments would increase for hospitals serving more severely ill patients and decrease for those serving patients who are less severely ill.

This year's inpatient hospital rule aims to improve the reliability and quality of care by continuing to expand the number of publicly reported quality measures. Also for the first time, CMS is recognizing hospital-acquired conditions and will ensure that Medicare no longer pays hospitals for the additional costs of cases with these conditions.

CMS has also issued proposed rules for skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities. The SNF proposal provides a 3.3 percent update and seeks comment on the forecast error adjustment. IRFs are also given a 3.3 percent update, and the proposal seeks comment on whether some or all of the existing co-morbidities should be included and calculated in compliance with the 75 percent rule, which aims to promote access to care for beneficiaries who require specialized and intensive rehabilitation care furnished in rehabilitation facilities.

The proposed rule for home health features the first major set of refinements since the advent of its prospective payment system in 2000. Research conducted by Medicare contractor APT Associates identifies two significant areas for payment requirement, therapy thresholds and case mix changes. This research was vetted thoroughly with the stakeholder community in 2005 and 2006.

Finally, CMS has issued the final long-term care hospital rule, which continues the agency's efforts to ensure Medicare is paying appropriately for medically complex patients. The rule advanced recommendations to short stay outlier policy and modified the 25 percent rule to include freestanding facilities.

In addition, it identified next steps CMS will pursue in working with the industry to develop patient and facility criteria for LTCHs. This effort stems from a MedPAC recommendation and subsequent research CMS conducted with it's contractor RTI.

Mr. Chairman, CMS is firmly committed to implementing rational and responsible policies to ensure that Medicare remains fiscally sustainable. The actions we take now would directly impact our ability to preserve the promise of healthcare coverage for America's seniors, people with disabilities and low-income, vulnerable populations.

We look forward to working with Congress in the coming year to reform Medicare's fee-for-service payment systems, in particular those that impact the providers we are discussing today.

I would be happy to answer any questions the Committee might have.

[The prepared statement of Mr. Kuhn follows:]

Testimony of
Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Before the
House Ways and Means Subcommittee on Health
Hearing on
Medicare Institutional Providers: Acute and Post-Acute Care
May 15, 2007

Chairman Stark, Mr. Camp, distinguished members of the Committee, thank you for inviting me here today to discuss Medicare's payment systems and payment updates for acute and post-acute care providers. The Centers for Medicare & Medicaid Services (CMS) looks forward to working with Congress in the coming year to build on our efforts to reform Medicare's fee-for-service payment systems and to work towards the shared goal of delivering the highest quality care to Medicare beneficiaries.

As the President's Fiscal Year (FY) 2008 Budget proposals and recent rulemaking efforts demonstrate, CMS is committed to ensuring that Medicare providers are paid appropriately for services furnished to Medicare beneficiaries, that Medicare beneficiaries have access to high-quality care in the most appropriate setting, and that Medicare's payment systems encourage the efficient delivery of quality care. My testimony will offer specific highlights from the President's FY 2008 Budget, and will then summarize our recent rulemaking efforts in the areas of hospitals, long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies.

President's Fiscal Year 2008 Budget Proposals

Federal Reserve Chairman Ben Bernanke, the Medicare Trustees, and the Medicare Payment Advisory Commission (MedPAC) have all stressed the importance of taking immediate action to ensure the long-term sustainability of the Medicare program. Recognizing the gravity of these warnings, the President's Budget proposes to strengthen the Medicare program by encouraging provider efficiency and productivity.

When combined with Medicare administrative proposals,[1] the FY 2008 Medicare legislative proposals included in the Budget would save $5.3 billion in FY 2008 and $75.9 billion over five years.[2] Among other things, the President's Budget would:

- Foster Productivity and Efficiency: By encouraging provider productivity and efficiency through payment adjustments, the Budget would slow cost growth;

- Encourage High Quality Care: The Budget would encourage high quality care by linking payment to the reporting of quality data, expanding on value-based purchasing for hospitals, and eliminating Medicare payment for never events;

- Improve Program Integrity: The Budget would improve program integrity by facilitating the proper coordination of benefits through improved data sharing, creating incentives for providers to recoup their debts, and strengthening the integrity of the administrative appeals process by limiting Mandamus jurisdiction as a basis for obtaining judicial review.

In addition to the proposals in the President's FY 2008 Budget, CMS remains committed to its core mission of encouraging continuous quality improvement across all of Medicare's payment systems. The policies included in the various proposed and final rules this year reflect CMS' efforts to ensure that all Medicare providers have incentives to furnish high quality, efficient care to beneficiaries and that Medicare pays appropriately for those services.

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[1] The Medicare budget assumes administrative savings of $1.0 billion in FY 2008 and $10.2 billion over five years. Savings will result from new efforts to strengthen program integrity in Medicare payment systems, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity.

[2] The savings estimates are net of a proposal in which Medicare funds are transferred to Medicaid to pay premiums for certain low-income individuals.

Fiscal Year 2008 Hospital Inpatient Prospective Payment System Proposed Rule

The proposed rule to update the FY 2008 hospital inpatient prospective payment system (IPPS) is estimated to increase payments to more than 3,500 acute care hospitals by $3.3 billion. The proposed rule also takes significant steps to improve payment accuracy, while providing additional incentives for hospitals to engage in quality improvement efforts. Reforms include proposals to restructure the inpatient diagnosis related groups (DRGs) to more accurately account for patient severity, ensure that Medicare no longer pays hospitals for the additional costs of hospital-acquired conditions (including infections), and expand the list of publicly reported quality measures.

These proposed reforms continue our efforts, for the third consecutive year, to implement the most significant revision of Medicare's IPPS since 1983. They are measured steps to improve the accuracy of Medicare's payment for inpatient stays to better account for the severity of the patient's condition. They continue changes begun last year to improve the accuracy of Medicare's inpatient hospital payments by using hospital costs rather than charges to set rates. They adjust payment under the IPPS to better recognize severity of illness and the cost of treating Medicare patients by increasing payment for some services and decreasing payment for others. They also will help eliminate biases in the current system that provide incentives for physician-owned specialty hospitals to treat the healthiest and most profitable cases, leaving the sickest and more costly patients to be treated in general acute care hospitals.

Specifically, the proposed rule would create 745 new severity-adjusted diagnosis related groups (Medicare Sev

The new DRG system presents opportunities to change documentation and coding practices to receive higher payments without a real increase in patient severity of illness. Without an adjustment to the IPPS rates to account for this case mix growth, the proposed MS-DRGs would not be budget neutral as required by statute. The CMS Office of the Actuary estimates that an adjustment of 2.4 percent to the IPPS rates for both FY 2008 and FY 2009 will be necessary to account for the anticipated improvements in coding and documentation. CMS will revisit these adjustments in two years if projected and actual data are different.

Prior to FY 2007, the DRG relative weights were based on hospital charges. Basing DRG relative weights on costs instead of charges improves the accuracy of payments, leading to better incentives for hospital quality and efficiency and ensuring that payment rates relate more closely to patient resource needs. In FY 2007, CMS adopted cost weights using hospital data for 13 separate departments over a 3-year transition period. The proposed rule for FY 2008 would continue to phase-in this change to better align payment with the costs of care by using estimated hospital costs, rather than charges, to establish relative weights for the DRGs. Under the proposed rule, hospitals would be paid during FY 2008 based on a blend of one-third charge-based weights and two-thirds cost-based weights for the DRGs. In FY 2009, hospitals would be paid based on 100 percent cost-based DRG weights.

Under the statute, in addition to the base payment for the DRGs, Medicare makes a supplemental outlier payment to a hospital if the estimated costs for treating a particular case exceed the usual Medicare payment for that case by a set threshold. Medicare sets the threshold for high-cost cases at an amount projected to ensure that total outlier payments equal 5.1 percent of total inpatient hospital payments. For FY 2008, CMS is proposing to adopt a high-cost outlier threshold of $23,015, down from $24,475 in FY 2007. CMS is proposing to lower the outlier threshold because fewer cases will be paid as outliers under the revised DRG system, which will more accurately account for patient severity. With the lower threshold, however, CMS projects that it will continue to pay between 5 and 6 percent of total IPPS payments as outliers, as required by law.

In keeping with the Agency's commitment to health care quality, the proposed rule would implement a provision of the Deficit Reduction Act of 2005 (DRA) that takes the first steps toward preventing Medicare from paying hospitals more for the additional costs treating a patient that acquires a condition (including an infection) during a hospital st The DRA requires hospitals to begin reporting secondary diagnoses that are present or patient's admission, beginning for discharges on or after October 1, 2007. The DRA a requires the Secretary of Health and Human Services (HHS) to select at least two conditions that are (1) high cost, high volume or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and (3) are reasonably preventable throu application of evidence-based guidelines. Beginning in FY 2009, cases with these conditions would not be paid at a higher DRG unless they were present on admission. The proposed rule identifies six conditions, including three serious preventable events (sometimes called "never events"), that meet the statutory criteria for payment adjustn in FY 2009. CMS seeks public comment on seven additional conditions that could be considered for future years.

The proposed rule recommends changes to the way Medicare pays for hospital capital-related costs based on an analysis that showed substantial positive margins experience by some hospitals. The rule recommends a full capital payment update for rural hospi and no update for urban hospitals. The rule also proposes to eliminate the large urban add-on payment and seeks comment on gradually discontinuing the teaching and disproportionate share (DSH) adjustments to capital payments.

In the FY 2007 IPPS and the CY 2007 hospital outpatient prospective payment system (OPPS) final rules, consistent with requirements in the DRA for CMS to expand the "starter set" of 10 quality measures that have been used since 2003, CMS added new measures to the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The FY 2008 IPPS proposed rule continues the effort by proposing to add five new quality measures, bringing to 32 the number of measures th hospitals would need to report in FY 2008 to qualify for the full market basket update

FY 2009. The five additional proposed measures include 30-day mortality for Medicare patients with pneumonia, and four measures relating to surgical care improvement. The proposed rule also seeks public comment concerning other measures that could be added for FY 2009 and beyond. In addition to this expansion of inpatient quality measures, the CY 2007 OPPS final rule announced plans to extend quality reporting to outpatient hospitals. Payment rate increases in the outpatient setting will be tied to the reporting of quality measures beginning in 2009. CMS plans to develop quality measures that are specifically appropriate for hospital outpatient care to promote greater value in the purchase of hospital outpatient services for Medicare beneficiaries. As required in section 109 of the Tax Relief and Health Care Act of 2006 (TRHCA), for hospitals that do not submit data on quality measures, the outpatient department fee schedule increase factor will be reduced by two percentage points beginning in 2009.

Finally, to foster transparency and patient safety, CMS is proposing to create new disclosure requirements for specialty hospitals. Physician-owned facilities would have to disclose such ownership to patients and provide the names of the physician owners upon request. Physician-owners who are members of the hospital's medical staff would also be required to disclose their ownership to the patients they refer to the hospital at the time of referral. CMS would have the authority to terminate a provider agreement for noncompliance with these disclosure requirements. In addition, the proposed rule would require a hospital to notify all patients in writing if a doctor of medicine or doctor of osteopathy is not present in the hospital 24 hours a day, seven days per week, and describe how the hospital will meet the medical needs of a patient who develops an emergency condition while no doctor is on site.

Rate Year 2008 Final Rule for Long-Term Care Hospitals

The final rule to update the payment rates and policies for the long-term care hospital prospective payment system (LTCH PPS) for the 2008 Rate Year (RY) assures appropriate payment for services furnished to severely ill patients and patients with medically complex conditions, while providing incentives to long-term care hospitals

(LTCHs) to furnish more efficient care to Medicare beneficiaries. Total Medicare payments to LTCHs in RY 2008 are expected to exceed $4 billion.

LTCHs are generally defined as hospitals that have an average Medicare inpatient length of stay of greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who may suffer from multiple acute or chronic conditions or require clinically complex care. Services typically include respiratory therapy and management of complex medical and post-surgical patients who have had prolonged illnesses.

Implemented in FY 2003 and updated annually, the LTCH PPS sets Medicare reimbursement for approximately 400 LTCHs. CMS is updating the LTCH PPS Federal rate by 0.71 percent to $38,356.45 for patient discharges occurring on or after July 1, 2007 through June 30, 2008. This update is based on the most recent estimate of the market basket applicable to LTCHs, which is 3.2 percent for RY 2008, and the most recently available LTCH case-mix data. CMS analysis of LTCH claims data indicates that a significant portion of the estimated increase in observed case mix between FY 2004 and FY 2005 is due to changes in coding practices and documentation rather than the treatment of more resource intensive patients. CMS, therefore, is adjusting the Federal rate for the estimated 2.49 percent increase in apparent case mix due to changes in coding practices.

Similar to the outlier policy under the IPPS, Medicare pays LTCHs an additional amount for treating unusually high-cost cases. To be eligible for outlier payments, the hospital's estimated costs in treating a given case must exceed the long-term care diagnosis-related group (LTC-DRG) payment by an outlier fixed-loss amount. For RY 2008, that fixed-loss amount is set at $22,954 – up from $14,887 the year before. The revision ensures that estimated aggregate outlier payments do not exceed 8 percent of estimated total payments under the LTCH PPS.

Because the LTC-DRGs are the same DRGs used under the IPPS, although weighted to reflect the greater complexity of LTCH cases, and these refinements would improve the recognition of severity of illness among LTCH patients, CMS has proposed to adopt the same DRG refinements proposed in the FY 2008 IPPS proposed rule for acute care hospitals paid under the IPPS for LTCHs as well. If adopted, these changes will take effect under both payments systems on October 1, 2007.

In the LTCH PPS final rule for RY 2008, CMS is extending the "25 percent rule", which currently applies a payment adjustment only to LTCHs and satellite facilities of LTCHs that discharge patients that were admitted from their co-located host hospital (generally an acute care hospital). The RY 2008 final rule provides for application of the payment adjustment to LTCHs and satellites of LTCHs (including grandfathered facilities) that admit patients from referring hospitals that are not co-located with them and that cause the LTCH or LTCH satellite to exceed a specific threshold of discharges admitted from that referring hospital. It also provides for a similar payment adjustment for grandfathered LTCH hospitals-within-hospitals and LTCH satellite facilities that admit patients from hospitals that are co-located with them. The rule also provides a 3-year transition period for the implementation of these provisions. In the first year of the transition the threshold may not exceed 75 percent. During the transition period, CMS will continue to explore implementing a recommendation from MedPAC to develop facility and patient-level criteria for LTCHs. In 2004, CMS contracted with RTI to perform a comprehensive analysis of the feasibility of developing assessment criteria. CMS is reviewing and evaluating the recommendations made by RTI in their final report, and will continue to engage interested parties in the possible development of a tool to assist in identifying patients that would be better suited to receive treatment in a LTCH setting.

Finally, CMS is revising the current payment adjustment formula as it applies to short-stay outlier discharges from a LTCH that have a length of stay (LOS) that is less than or equal to an "IPPS-comparable threshold." Beginning with discharges on or after July 1, 2007, Medicare will pay for these discharges with an LTCH PPS amount not to exceed

the "comparable IPPS per diem amount" for that particular DRG. This approach will result in appropriate Medicare payments for those cases that are admitted and treated at LTCHs, but that have a LOS similar to cases typically treated in acute care hospitals paid under the IPPS. For short-stay outlier cases where the length of stay exceeds the "IPPS-comparable threshold," payment would be made under the existing short-stay outlier policy.

Fiscal Year 2008 Proposed Rule for Inpatient Rehabilitation Facilities

After an illness, injury, or surgical care, some patients need intensive rehabilitation services, such as physical, occupational, or speech therapy. Inpatient rehabilitation facilities (IRFs) are designed to offer specialized rehabilitative care to patients with the most intensive needs and Medicare pays IRFs at a higher rate than some other hospitals in recognition of this.

In FY 2008, Medicare will pay approximately $6.3 billion to more than 1,200 IRFs. The FY 2008 proposed rule to update payments under the IRF prospective payment system (IRF PPS) would increase Medicare payments to IRFs by approximately $150 million. This includes a 3.3 percent payment increase, based on the rehabilitation, psychiatric and long-term care hospital (RPL) market basket. The RPL market basket is designed to capture inflation in the costs of goods and services required to provide the specialized services offered by these facilities, similar to the market basket that applies to general acute care hospitals.

The classification criterion – also known as the "75 percent rule" – used to classify a hospital or hospital unit as an IRF that is subject to the IRF PPS was determined through consultation with the industry and adopted through the rule-making process. Initially adopted in 1983 to distinguish those hospitals and hospital units that would be eligible for exemption from the IPPS, this classification criterion continues to be applied to distinguish IRFs from acute care hospitals by ensuring that a minimum percentage of a facility's total inpatient population is composed of patients who require intensive rehabilitative services for the treatment of at least one of thirteen medical condi

specified in regulations. This minimum percentage is known as the compliance threshold. CMS's intent in adopting the 75 percent rule was to protect patient access to care by providing IRFs with some flexibility when admitting patients. As long as the required percentage of a facility's total inpatient population require intensive rehabilitative services for at least one of the 13 specified medical conditions specified in the regulations, the facility can maintain its status as an IRF and have the flexibility to offer their highly specialized services to patients who do not meet those specified conditions. During the transition period provided for in the regulations, a comorbidity meeting conditions specified in the regulations may also be counted toward the applicable threshold.

As enforcement of the 75 percent rule gradually phases in from July 1, 2004 through July 1, 2008, Medicare claims data have demonstrated that patients – who might have been treated in an IRF (but who have clinical conditions appropriate for care outside of an IRF) – are now getting needed care in other more appropriate and less costly settings. Accordingly, the FY 2008 IRF PPS proposed rule does not change the phase-in to the full 75 percent compliance threshold as the appropriate threshold that maintains an IRF's flexibility in admitting patients, while ensuring that care is delivered in the most appropriate setting.

The 75 percent compliance threshold is being phased in according to the following methodology. CMS uses the start of a provider's cost reporting period to determine which compliance threshold to apply to determine if a hospital should be classified as an IRF. For example, in accordance with Section 5005 of the Deficit Reduction Act of 2005 (DRA), a 60 percent threshold applies for cost reporting periods beginning during the 12 month period beginning on July 1, 2006. The compliance threshold increases to 65 percent for cost reporting periods beginning during the 12-month period beginning on July 1, 2007. For cost reporting periods beginning on and after July 1, 2008, the compliance threshold is 75 percent.

For the cost reporting periods that begin before July 1, 2008, the 75 percent rule regulations allow co-morbidities that meet the regulatory criteria to be used to determine the compliance percentage. This transitional provision expires for cost reporting periods that will begin on or after July 1, 2008. The proposed rule does not extend its application, but CMS is soliciting comments and research on current policy or other options, including extending this provision for a specified time or making it a permanent part of the IRF PPS policy.

In addition, the proposed rule would increase the high-cost outlier threshold to $7,522 from $5,534 in FY 2007, based on an analysis of 2005 data which indicates that the proposed threshold would maintain estimated outlier payments at 3 percent of total payments under the IRF PPS. Although the higher threshold would mean that fewer cases would qualify for outlier payments, a lower outlier threshold would require an across-the-board reduction in the base payment for an IRF stay in order to maintain budget neutrality. The high-cost outlier threshold may be updated for the final rule based on analysis of 2006 data. The proposed rule would also clarify that short-stay transfer cases that meet the criteria to qualify for outlier payments are eligible to receive the additional payments.

Fiscal Year 2008 Proposed Rule for Skilled Nursing Facilities

Under the FY 2008 proposed rule to update the skilled nursing facility prospective payment system (SNF PPS), Medicare payments to skilled nursing facilities (SNFs) would increase by approximately $690 million. This 3.3 percent increase reflects CMS' commitment to improving the quality of care in the long-term care setting while maintaining predictability and stability in payments for the nursing home industry. The new proposed payment rates also continue to include a special adjustment to cover the additional services required by nursing home residents with HIV/AIDS.

CMS uses a SNF market basket to measure changes in the prices of an appropriate mix of goods and services included in covered SNF stays. The price of items in the SNF market basket is measured each year, and Medicare payments are adjusted accordingly. The

proposed rule includes a proposal to update the SNF market basket, which currently reflects FY 1997 data, to reflect FY 2004 data. Other proposed revisions include updating the SNF market basket inputs, using Medicare allowable total cost data (rather than total facility cost data) to derive the SNF market basket cost weights, and creating two new cost categories: professional liability insurance and postage.

To help distinguish between major forecast errors and more typical minor variances, the proposed rule would revise the threshold for the difference between the forecasted and actual change in the market basket triggering a forecast error adjustment from the current 0.25 percentage point threshold to 0.5 percentage point, effective with FY 2008.

Calendar Year 2008 Proposed Rule for Home Health

Under the CY 2008 proposed rule to update the home health prospective payment system (HH PPS), payments to home health agencies (HHAs) would increase by an estimated $140 million. This proposed rule reflects CMS' commitment to ensuring more appropriate payment for services provided by Medicare HHAs, while establishing incentives for more efficient care for Medicare beneficiaries.

The proposed rule increases the home health market basket by 2.9 percent. It also contains a provision to continue to adjust payment for the reporting of quality data. HHAs that submit the required quality data would receive payments based on the proposed update of 2.9 percent for CY 2008. HHAs that do not submit quality data would have their increase reduced by 2 percentage points to 0.9 percent for CY 2008. Additionally, CMS analysis of claims data indicates that a significant portion of the recent increase in observed case mix is due to changes in coding practices and documentation rather than treatment of more resource intensive patients, and this rule proposes to reduce the national standardized 60-day episode payment rate by 2.75 percent per year for three years beginning in CY 2008 to account for these changes in case-mix that is not related to a home health patient's actual clinical condition.

In addition, this proposed rule includes the first proposed refinements to the HH PPS since the inception of the payment system. These proposed refinements would improve the comprehensiveness of the case-mix model in the HHS PPS and thus improve the accuracy of Medicare's payments. One example is a proposal to replace the current therapy threshold at 10 visits with three new therapy thresholds at six, 14, and 20 therapy visits. These changes would significantly increase the case-mix model's ability to more appropriately reflect HHA costs and consequently provide more accurate payments to HHAs. In addition, in response to ongoing concerns about the inadequacy of the current payment for non-routine medical supplies under the HH PPS, the rule proposes to replace the existing approach with a system that pays for non-routine medical supplies adjusted for a patient's severity.

Post-Acute Care Payment Demonstration

As discussed above, Medicare currently covers post-acute care services in a variety of settings, including long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies. Medicare's post-acute care benefits and payment policies currently focus on the site of service instead of the characteristics and needs of the particular beneficiary. As a result, payments across settings may differ considerably even though the clinical characteristics of the beneficiary and the services delivered are very similar.

Section 5008 of the DRA authorizes a post-acute care payment reform demonstration, requiring the Secretary to establish a demonstration program by January 1, 2008 that would use a comprehensive assessment tool at hospital discharge to determine appropriate post-acute care placement based on patient care needs and other characteristics. Under the demonstration, a standardized patient assessment instrument will be used. This instrument referred to as CARE (Continuity Assessment Record & Evaluation) will be comprehensive, interoperable and implemented on a secure internet based platform, with the objective of enhancing beneficiaries' safety with transfers between settings and deliver critical health care information to providers in real time.

Conclusion

Mr. Chairman, thank you again for the opportunity to appear before you today. CMS is firmly committed to implementing rational, responsible, and sustainable policies to ensure the fiscal sustainability of the Medicare program. Our actions now will directly impact our ability to preserve the promise of health care coverage for America's seniors, people with disabilities, and low-income, vulnerable populations. We look forward to working with Congress in the coming year to build on our efforts to administratively reform Medicare's fee-for-service payment systems – including those that impact the institutional providers we are discussing today.

I would be happy to answer any questions at this time.

Chairman STARK. Thank you.
Mark?

STATEMENT OF MARK MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT AND ADVISORY COMMISSION

Mr. MILLER. Chairman Stark, Ranking Member Camp, distinguished Subcommittee Members, as you know, MedPAC is a congressional support agency created to advise Congress on Medicare policy. As you know, we have 17 commissioners from diverse backgrounds that review the work produced by the staff and shape the advice that we forward to the Congress.

As we consider our policy advice to Congress we keep a couple of principles in mind, assuring that beneficiaries have access to quality care, assuring that taxpayer dollars are spent wisely and then designing payment systems for providers that assure this access but also assure that care is provided efficiently. In this instance efficiently means not just lower spending if that's appropriate but also higher quality at the same level of spending.

There are other considerations that I know are on the mind of commissioners. First there is a long run sustainability problem for Medicare. Medicare is growing faster than the budget, the economy and beneficiary incomes. But these spending increases have not been consistently accompanied by improvements either in coordination or the quality of care.

We believe attention is needed to improve payment and delivery system incentives as part of the solution to correcting Medicare's long run sustainability issues.

Second, Medicare policies must evolve to be more sensitive to the performance of providers. That is, we should pay more to providers who use resources wisely and provide high quality care, we should pay less to those who do not.

Third, that as a payer Medicare must maintain physical pressure on providers in order to assure that providers are constantly en-

gaged in spending carefully and improving the quality of care that they provide.

The testimony I submitted discusses policies related to fee-for-service hospitals and to post-acute care. I will just note a few ideas and then take other questions for more details. MedPAC has previously made recommendations to establish a budget neutral pay-for-performance system for hospitals and home health agencies. We have also called for refinements to the hospital underlying payment system for hospitals, skilled nursing facilities and home health agencies.

Regarding payment policy, as mandated by law each year we are asked to make recommendations on payment updates to Congress. We consider several factors, supply of providers, access to service, how much Medicare pays relative to providers' costs.

With respect to hospitals the commission finds that most measures of financial performance are positive. For example, access is good, service volume is increasing and spending on capital is at an all time high. However there is some bad news. Medicare margins, the amount Medicare pays above cost, are negative and falling.

Part of the reason that these margins are low is because hospitals have had high rates of cost growth. We think that part of the reason they have had high rates of cost growth is that private payers have not put significant fiscal pressure on hospitals to contain their costs. We find, for example, that hospitals that have consistently poor Medicare performance are also hospitals that are paid well above their costs by private payers and hence have higher costs per case and higher growth in cost per case.

So, taking this evidence into account the commission tried to strike a balance between these various indicators and the need to maintain fiscal pressure. We have recommended a full market basket increase for hospitals but implemented concurrently with a budget neutral pay-for-performance system for hospitals. The pay-for-performance policy would redistribute dollars among hospitals so that the net payment to high quality hospitals would be greater than a market basket alone and the net payment to low quality hospitals would be less than the increase for a market basket alone. In other words, we do not believe that all hospitals are entitled to a net increase in payments equal to the full market basket.

In a previous report on specialty hospitals, the commission made a series of recommendations to improve the underlying hospital payment system by refining the payments to remove distortions that make some services systematically more profitable than others and to better account for differences in patient severity.

Regarding post-acute care services, home health SNF, long-term care hospitals and inpatient rehab, generally the picture is positive. There's an adequate supply of providers. Beneficiary access is good. Volume of services is generally increasing and through 2005 Medicare payment exceeded cost by a wide margin.

However, looking forward to 2007, some circumstances have changed. For inpatient rehab facilities and long-term care hospitals, changes in the regulatory environment will bring payments for these facilities down. But in evaluating these impacts the commission chose to recommend a small, one percent update for inpa-

tient rehab facilities and a zero percent update for long-term care hospitals.

Regarding long-term care hospitals, a few years ago MedPAC made recommendations to implement patient and facility criteria that would better target services to Medicare beneficiaries. Finally, projecting forward for home health and skilled nursing facilities, we continue to see that Medicare payments far exceed costs and have recommended zero updates in these areas.

I look forward to your questions.

[The prepared statement of Mr. Miller follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Payments to Selected Medicare Fee-for-Service Providers

May 15, 2007

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Chairman Stark, Ranking Member Camp, distinguished Subcommittee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss Medicare fee-for-service payments to certain Medicare fee-for-service health care providers. As you know, MedPAC has particular expertise and an extensive track record in this area. In its work on Medicare payment policy, the Commission has consistently conducted its analytic work guided by three key principles to ensure a conceptual consistency in Medicare fee-for-service payments: Medicare payment systems should ensure beneficiary access to high-quality care in an appropriate setting, they should give providers an incentive to supply care efficiently, and they should appropriately control program spending.

The Commission has become increasingly concerned with the trend of higher Medicare spending—at a growth rate much higher than for the economy overall—without a commensurate increase in value to the program, such as higher quality of care or improved health status. Despite this rapid growth in spending, large gaps in the quality of care that is delivered persist, as the Institute of Medicine and others have documented in recent years. The growth in spending, combined with retirement of the baby boomers and Medicare's new prescription drug benefit, will, if unchecked, result in the Medicare program absorbing unprecedented shares of the gross domestic product and of federal spending. Slowing the increase in Medicare outlays is important; indeed, it is becoming urgent. Medicare's rising costs, particularly when coupled with the projected growth in the number of beneficiaries, threaten to place a significant burden on taxpayers. Rapid growth in expenditures also directly affects beneficiary out-of-pocket costs through higher Part B and supplemental insurance premiums as well as higher copayments. Policymakers need to take steps now to slow growth in Medicare spending and encourage greater efficiency from health care providers, while ensuring access and maintaining or improving quality.

In our March report to the Congress, we reviewed Medicare fee-for-service payment systems for eight sectors: hospital inpatient, hospital outpatient, physician, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCH). Today, my remarks touch on all these providers except for physicians, because of the focus of this hearing. The Commission recommended changes to payment and other policies

designed to make payments more accurate and to improve the value received by beneficiaries and taxpayers for their expenditures on health care. A common theme in the Commission's recommendations for these systems is that Medicare should exert continued financial pressure on providers to control their costs, much as would happen in a truly competitive marketplace. We have found, for example, that hospitals under financial pressure from private payers tend to control cost growth better than those with non-Medicare revenues that greatly exceed their costs.

In all sectors, Medicare should also adjust payments for quality, paying more for high quality and less for poor quality. Further, Medicare must adjust its payment systems to furnish incentives for providers to increase their efficiency in providing health care; in essence, the program's payment systems must better reward providers who take positive steps to control their costs, rather than simply allowing payments to increase in lockstep with growth in health care costs. Because there are numerous payers in the U.S. health care system, achieving gains in efficiency is difficult for any one payer. To engender broader changes among U.S. providers, Medicare will likely need to collaborate with other payers but can take a leading role in driving change.

Assessing payment adequacy and updating payments in fee-for-service Medicare

In its March 2007 report to the Congress, the Commission recommended payment updates for 2008 and other policy changes for fee-for-service Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system (PPS) is changed. To help determine the appropriate level of aggregate funding for a given payment system, the Commission considers whether current Medicare payments are adequate by examining information about beneficiaries' access to care; changes in provider supply and capacity; volume and quality of care; providers' access to capital; and, where available, the relationship of Medicare payments to providers' costs. Ideally, Medicare's payments should be linked to the costs of efficient providers, who use fewer inputs to produce quality services. We then account for expected cost changes in the next payment year, such as those resulting from changes in input prices.

Improvements in productivity reduce providers' costs in the coming year. Medicare's payment systems should encourage providers to reduce the quantity of inputs required to produce a unit of service by at least a modest amount each year while maintaining service quality. Thus, in most cases in which payments are adequate, some amount representing productivity improvement should be subtracted from the initial update value, which is usually an estimate of the change in input prices. Consequently, we apply a policy goal for improvement in productivity (the 10-year average of productivity gains in the general economy, which is currently 1.3 percent). This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. Competitive markets demand continual improvements in productivity from these workers and firms; as a prudent purchaser, Medicare should expect the same of health care providers.

Hospital inpatient and outpatient services

Most indicators of payment adequacy for hospitals are positive. More Medicare-participating hospitals have opened than closed in recent years. Inpatient and outpatient service volume continues to increase but at reduced rates of growth in 2005 and into 2006, partly due to the increase in beneficiary enrollment in Medicare Advantage plans. The quality of care hospitals provide to Medicare beneficiaries is generally improving. Spending on hospital construction increased substantially in recent years (up 30 percent in 2006 alone), while the median values of several financial indicators (such as measures of debt service coverage) reached their best value ever recorded in 2005.

Hospitals with consistently lower Medicare margins (the excess of payments over costs divided by payments) over the last three years tend to have higher private payer payments. Those higher payments allow hospitals to continue to have higher costs, and thus they are under less pressure to control costs. Table 1 shows that hospitals with consistently low Medicare margins over the last three years had revenues from non-Medicare payers that were 1.16 times the hospitals' costs for providing the services. Conversely, hospitals with consistently high Medicare margins had non-Medicare revenues just under their costs. Those hospitals were under pressure to control their costs and did so more successfully, with costs increasing at a lower rate and length of stay decreasing at a faster rate than hospitals with consistently low margins. As a result, in 2005, hospitals with low Medicare

margins were less competitive with nearby hospitals and those with high Medicare margins more competitive.

Table 1. Hospitals with consistently low or high adjusted overall Medicare margins face different cost pressures

	Hospitals' adjusted Medicare margins:	
Indicators:	Consistently low	Consistently high
Non-Medicare ratio of revenues to costs (2005)	1.16	0.99
Average annual percent increase in inpatient cost per case (2002–2005)	6.3%	5.2%
Annual percent change in Medicare length of stay (1997–2005)	–2.3	–3.1
Standardized cost per case (2005):		
Subject hospital	$6,203	$4,527
Hospitals within 15 miles	5,742	5,103

Note: Hospitals with consistently low or high margins had adjusted overall Medicare margins (margins calculated excluding indirect medical education and disproportionate share payments over empirically justified amounts) from 2002 to 2005 that were in the top or bottom third each year. Per cases costs are standardized for wages, case mix, severity, outlier cases, and teaching intensity. Median values are shown.

Source: MedPAC analysis of data from CMS.

Hospitals exhibit a wide range of costs per discharge, even after controlling for factors that are largely outside the control of hospital management. In 2004, for example, the 90th percentile value of standardized Medicare costs per discharge was 46 percent higher than the 10th percentile value. Excluding hospitals with consistently high standardized costs (about 17 percent of hospitals) would raise the industry-wide Medicare margin by 3 percentage points.

Lack of pressure to control costs because of high non-Medicare revenues also may have contributed to continued high growth in costs per unit of service in 2006 and 2007, which in turn contributes to the negative Medicare margin (–5.4 percent) we project in 2007, a continued decline from the –3.3 percent margin we observed in 2005.

Balancing positive indicators and negative margins, the Commission recommended that the Congress update both inpatient and outpatient payments by the increase in the hospital market basket for fiscal year 2008, with this increase implemented concurrently with a quality incentive payment program. A pay-for-quality-performance program would pay

those hospitals with higher quality more than the basic payment rate. Although such a quality program would operate separately from the update, it is essential that the pay-for-quality program be implemented at the same time as the payment update for the next fiscal year. This means the net increase in payments would be less than the market basket; to receive more, hospitals would have to achieve better performance on their quality scores.

Part of the funding for a quality incentive payment policy for all hospitals should come from reducing payments for indirect medical education (IME). Our analysis finds that more than half of the IME add-on payment is unrelated to the additional cost of care that results from the intensity of a hospital's teaching program (measured by the resident-to-bed ratio). The Commission recommends that the Congress reduce the IME adjustment by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio, concurrent with implementation of a system for adjusting payments for severity of illness. Teaching hospitals as a group already have better financial performance than nonteaching hospitals under Medicare. They will also benefit from the severity adjustments to hospital payments that CMS is proposing for fiscal year 2008, which are necessary to help improve the accuracy of the payment system.

Our recommendations on the update and IME payments, along with the proposed severity adjustments and a focused pay-for-performance initiative, should be viewed as a package that will improve the accuracy of Medicare's acute inpatient payments while creating an incentive for improving the quality of care.

For several years, policymakers have considered options for the federal government to help hospitals with their uncompensated care. We found little evidence of a relationship between the disproportionate share payments hospitals receive and the amount of uncompensated care they provide. If policymakers desire to provide a federal payment for uncompensated care, it should be distributed on the basis of each hospital's total amount of uncompensated care, not as an add-on to a Medicare per case payment rate. To provide the necessary data, the Commission recommends that CMS improve its instrument for collecting information on uncompensated care. The Commission previously suggested specific changes to help CMS revise its data collection instrument.

Outpatient dialysis services

Most of our indicators of payment adequacy for outpatient dialysis services are positive. Beneficiaries' access to dialysis care is generally good; the number of facilities increased, capacity increased, and there do not appear to be access problems. The growth in the number of dialysis treatments kept pace with growth in the number of patients. Recent evidence about trends in opening new dialysis facilities suggests that providers have sufficient access to capital. Between 2003 and 2005, the cost per treatment for composite rate services and dialysis drugs fell, largely driven by decreases in drug prices. We project that Medicare payments will cover the costs of providing outpatient dialysis services to beneficiaries in 2007 with a margin of 4.1 percent, compared with an 8.4 percent Medicare margin for freestanding facilities in 2005. Quality of care is improving for some measures; more patients are receiving adequate dialysis and more have their anemia under control. Yet, one quality measure—patients' nutritional status—has not improved during the past five years.

Considering expected input costs and our payment adequacy analysis, the Commission recommends that the Congress update the composite rate for outpatient dialysis services in 2008 by the projected change in input prices less the Commission's expectation for productivity growth.

The Commission remains concerned that Medicare continues to pay separately for drugs and laboratory tests that providers commonly furnish to dialysis patients. Medicare could better control costs and promote access to quality services if all dialysis-related services, including drugs, were bundled under a single payment, a recommendation the Commission has made previously. In addition to broadening the payment bundle, the Secretary should continue efforts to improve dialysis quality. The Commission has previously recommended that Medicare base a portion of payments on the quality of care furnished by facilities and physicians who treat dialysis patients. The Secretary also needs to continue to develop quality measures and to monitor and improve dialysis care. Together, these steps should improve the efficiency of the payment system, better align incentives for providing cost-effective care, and reward providers for furnishing high-quality care.

Post-acute care providers

The recuperation and rehabilitation services that post-acute care (PAC) providers furnish are important to Medicare beneficiaries. In our March 2007 report, the Commission analyzed payment adequacy for several types of PAC providers, including skilled nursing facilities (SNFs), home health agencies (HHAs), IRFs, and LTCHs.

PPSs for each setting were developed and implemented separately. As a result, Medicare's payments for similar (if not identical) PAC services can vary considerably, depending on the setting where they are provided. For example, the Commission reported in its June 2005 report to the Congress that patients recovering from hip or knee replacement on average cost $3,400 more to treat in IRFs than in SNFs, even after controlling for patient characteristics. This raises questions about whether the more expensive setting provides better value to Medicare or its beneficiaries. It is also possible that the financial incentives implicit in such payment differentials unduly influence where a beneficiary receives a given PAC service, especially if there are multiple settings that can provide the service in a given market. Additionally, payment inaccuracies *within* each of the PAC payment systems create incentives for providers to seek or avoid certain kinds of patients.

While the PPSs have changed the pattern of service use within each setting, we do not have adequate data to evaluate whether beneficiaries are being treated in the setting that provides the most value to them and the program. Three barriers undermine the program's ability to know if it is purchasing high-quality care in the least costly PAC setting consistent with the care needs of the beneficiary:

- Case-mix measures often do not accurately track differences in the costs of care.
- There is no common instrument for patient assessment across PAC settings, nor are there clear and comprehensive criteria for which setting is best for patients with particular characteristics or needs. This makes it difficult to compare costs, quality of care, and patient outcomes.
- There is a lack of evidence-based standards of care.

Similar barriers limit our ability to compare differences in financial performance among the providers within each post-acute setting. We do not know if better financial performance results from higher efficiency or from differences in the mix of patients chosen for treatment. We did find that facilities with lower costs and higher Medicare margins had consistently low unit costs, used fewer resources, and had higher occupancy.

CMS has begun, most recently in the form of a demonstration project mandated by the Deficit Reduction Act of 2005, to develop a uniform PAC patient assessment instrument. Such an instrument will be essential to the agency's larger goal of reforming Medicare's disparate PAC systems, so that Medicare payments are based on the clinical characteristics and care needs of the individual patient, irrespective of the setting where the patient receives care. A setting-neutral system of paying PAC providers based on patients' clinical characteristics would give providers incentives to provide high-quality care appropriate to patients' needs.

Skilled nursing facility services

Our indicators of payment adequacy are generally positive for SNFs, but quality shows a decline. Beneficiaries have good access to SNF care, although those who need certain expensive services may experience delays in finding SNF care and end up staying longer in the hospital. The number of facilities providing SNF care to Medicare beneficiaries has remained almost constant. SNFs appear to have good access to capital. Spending and volume of days and stays increased in 2005, with cases continuing to shift to rehabilitation case-mix groups, which receive higher payments. We project that Medicare payments will more than cover the costs of providing SNF care to Medicare beneficiaries in 2007, with margins for freestanding SNFs of around 11 percent, a small decline from the 12.9 percent margins reported in 2005. The data suggest that SNFs should be able to accommodate the cost increases anticipated in 2008 within existing payment levels. Therefore, the Commission recommends that the Congress should eliminate the update to payment rates for SNF services for fiscal year 2008.

Some have argued that, although Medicare payments may be more than adequate, Medicaid payments to nursing facilities are inadequate and, therefore, Medicare should increase its payments to SNFs. The Commission rejects this argument for three reasons. First, Medicare

payments should be set to cover the costs of an efficient provider, not to cover the additional costs of caring for non-Medicare patients. Second, increasing Medicare payments would target the wrong facilities; SNFs with more Medicare patients and fewer Medicaid patients would receive larger increases, and those with fewer Medicare patients and more Medicaid patients would receive smaller increases. Third, if Medicare took this perspective, states might scale back their spending in response.

Two outcome measures for Medicare SNF patients show declining quality in recent years: average facility rates of avoidable rehospitalizations increased and discharges to the community declined. SNFs that appeared to provide good quality using these two measures appeared to be poor-quality facilities using CMS's publicly reported PAC quality measures. This inverse relationship, combined with our previous concerns about the publicly reported measures, leads us to urge CMS to report community discharge rates and rehospitalization rates for Medicare patients and to reconsider our recommendation to change the timing of the patient assessments so that changes in health status are gathered for all patients.

The Commission and others have discussed the need for revising the SNF PPS to correct two key problems. First, under the current system patients who need expensive nontherapy ancillary services (such as drugs, intravenous medications, and respiratory therapy) may have difficulty accessing care. Second, the current payment system encourages providers to furnish therapy even when the services are of little or no value. Based on CMS's extensive research, we conclude that options can be designed to better target payments for nontherapy ancillary services and to discourage the provision of unnecessary therapy services. The options vary in the resources required for CMS to implement them, the changes providers would have to undertake, and the incentives to furnish inappropriate care.

Home health agencies

Our indicators for home health services are positive. Access to care continues to be satisfactory, with more than 99 percent of beneficiaries living in an area served by a HHA in 2006. The number of beneficiaries using HHAs increased from 2.7 million in 2004 to 2.9 million in 2005. The number of HHAs participating in Medicare increased by 6.5 percent in 2006. Our projection of the 2007 margin for freestanding agencies is 16.8 percent, up slightly

from the 2005 margin of 16.7 percent. Most quality indicators continue to show improvement, with more beneficiaries reporting improvements in walking, bathing, and other physical activities. The rate of rehospitalizations and emergency room use remains unchanged. The data suggest that HHAs will be able to absorb any cost increases in 2008 within current payment levels, and the Commission recommended that the Congress eliminate the payment update for home health care in 2008.

We have noted several issues with the PPS, which suggest that the current system may not reflect the costs of different types of patients or changes in the benefit since the PPS. The current typical home health episode includes fewer visits and a higher proportion of therapy than it did when the system was created. Medicare's system for classifying patient resource needs, the Home Health Resource Groups, may inappropriately group together patients with different resource needs. Also, MedPAC found that an agency's average case mix had a small but statistically significant relationship with profit margin. These factors suggest that the accuracy of the PPS could be improved. CMS recently released a rule that would refine the PPS for home health, and MedPAC is assessing how the proposed changes will affect payment accuracy.

Inpatient rehabilitation facility services

Medicare is the principal payer for IRF services, accounting for about 70 percent of discharges. Judging payment adequacy for IRFs since implementation of the IRF PPS in 2002 is now more difficult because of a major change in Medicare policy. The change was CMS's modification of the so-called "75 percent rule," which requires IRFs to have 75 percent of admissions with one or more of a specified list of conditions; 2005 was the first full year the rule took effect.

The intent of the 75 percent rule is to ensure that IRFs provide intensive rehabilitation services to unique types of patients; that is, those who really need and will benefit from the intensive level of care these facilities provide. For 20 years, from 1984 to 2004, the same diagnoses were included in the 75 percent rule. In 2002, CMS discovered that fiscal intermediaries were using inconsistent methods to enforce the 75 percent rule. As a result, CMS suspended enforcement of the rule until the agency could examine it and determine whether the regulation should be

modified. The goal of the modification was to identify a class of patients who could uniquely benefit from the intensive—and expensive—treatment IRFs provided. In 2004, CMS redefined arthritis conditions allowed to be treated in IRFs, which removed the largest single category of IRF admissions (major joint replacements) from the 75 percent rule and substituted three more precise conditions. CMS created a four-year transition period for compliance with the revised 75 percent rule. The Deficit Reduction Act of 2005 added a year to the transition. For IRFs with cost-reporting periods beginning July 2007, 65 percent of each IRF's cases must meet the new definition; for those cost-reporting periods beginning on or after July 2008, the threshold returns to the original 75 percent.

The number of IRF cases increased rapidly after introduction of the PPS in 2002 but decreased in 2005 as CMS began to phase in the revised 75 percent rule. We do not have direct evidence to indicate whether this drop in IRF cases reflects a problem with access to IRF care. However, we note that the policy was developed on the premise that IRFs were admitting patients whose severity of illness did not warrant the intensive (and costly) treatment that IRFs provide. For example, in 2005 the Government Accountability Office found that 87 percent of joint replacement patients treated in IRFs in 2003 did not meet the criteria for needing the level of care IRFs provide. We also note that patients who were no longer eligible for care in IRFs as a result of the new criteria could receive care in other settings such as SNFs, but again the lack of a uniform patient assessment instrument precludes us from knowing whether such shifts in setting are clinically appropriate in all cases.

Medicare spending for IRFs followed the same trends, increasing rapidly from 2002 to 2004 but decreasing from 2004 to 2005. Our other indicators show that the supply of IRFs was stable in 2005, the patients IRFs treated in 2005 were more complex than those IRFs treated in previous years. Most IRFs are hospital-based units that access capital through their parent institutions, which have good access.

As expected, in response to the modified 75 percent rule, growth in costs per case accelerated between 2004 and 2005. This is because, although the volume of cases declined, IRFs' patient mix became more complex as patients with lesser needs were treated in other settings.

Aggregate Medicare margins for 2005 were high, around 13 percent. These estimates are averages, however, and historically IRF margins have varied considerably. In 2005, for example, IRFs at the 25th percentile had margins of –4 percent, while IRFs at the 75th percentile had margins of 22 percent. We estimate that margins in 2007 will be lower, largely because of the effect of the 75 percent rule. We estimate that the margin will range between 0.5 and 5.5 percent, depending on the ability of the IRFs to control their costs to compensate for the drop in volume; IRFs better able to control their costs could expect Medicare margins at the higher end of this range. This possibility is borne out by MedPAC's analysis of the relationship between IRFs' costs and their Medicare margins presented in our March 2007 report to the Congress; IRFs that had consistently high Medicare margins had cost growth between 2003 and 2004 that was one-third the growth in costs of IRFs with consistently low Medicare margins. The Commission recommended that the Congress update payment rates for IRFs for 2008 by 1 percent.

Long-term care hospitals

Our indicators of payment adequacy for LTCHs are largely positive. LTCHs have entered the Medicare program at a rapid rate and publicly announced plans to open more LTCHs, suggesting that payment rates are attractive. (However, CMS data for 2006 suggest that the rate of growth in the number of LTCHs may be slowing.) The expanding supply of LTCHs has resulted in increases in the volume of discharges and in the number of beneficiaries using LTCHs. Medicare spending for LTCH services has grown sharply, climbing 29 percent per year between 2003 and 2005. Aggregate Medicare margins for 2005 are almost 12 percent. However, due to payment policy changes and expected increases in costs, we estimate that 2007 margins will range from 0.1 percent to 1.9 percent.

The evidence on quality in LTCHs is mixed. On the positive side, risk-adjusted rates of death and death within 30 days of discharge showed improvement between 2004 and 2005, as did the rate of postoperative sepsis. However, more patients were readmitted to acute care hospitals in 2005 than in 2004, and patients experienced more decubitus ulcers, infections and pulmonary embolisms or deep vein thromboses. These negative quality indicators are worrisome, especially since the number of patients treated in LTCHs is growing.

LTCHs can be either freestanding or located within hospitals (hospitals within hospitals or HWHs). CMS has established several policies directed at trying to keep HWHs and satellite facilities operating independently from their host hospitals. One policy, called the "25 percent rule," limits the proportion of patients who can be admitted from a HWH's host hospital during a cost-reporting period. When the policy is fully implemented in fiscal year 2008, a HWH will be paid LTCH PPS rates for patients admitted from its host acute care hospital as long as those patients do not exceed a threshold of 25 percent of the LTCH's cases. If more than 25 percent of the LTCH's cases are admitted from its host hospital, the excess cases will be paid the lesser of the LTCH PPS rate or an amount equivalent to the acute hospital PPS rate. (For rural HWHs and certain other HWHs, the threshold is 50 percent of cases. Patients who are transferred to a LTCH after being high-cost outliers in the host hospital are excluded from the threshold calculation and are paid at the LTCH PPS rate.)

mited b Recently, CMS extended this rule to freestanding LTCHs so that all LTCHs would be l in the number of patients they could admit from any one acute care hospital.

they ility

The Commission believes that, while LTCHs seem to have value for very sick patients, are too expensive for patients who could be treated in less intensive settings. We see fa and patient criteria as the best way to target LTCH care to patients who need it. We recommended the development and implementation of such criteria in 2004. Patie[illegible] criteria would identify specific clinical characteristics—such as the presence of specific conditions—and specific treatments required by patients cared for in LTCHs. Facility-b criteria would eliminate instances of the care provided in LTCHs, such as a patient's social and resource problems, cultural assessment tool, and physician availability requirements. Research Triangle Institute, which contracted with CMS to study the feasibility of implementing criteria for LTCHs, has explored several. MedPAC's recommendations approach such as the 25 percent rule may be administratively less complex than the application of patient clinical criteria, but it can be arbitrary and increases the risk of unintended consequences. MedPAC notes, however, the 25 percent rule and other administrative policies may have created pressure on the industry to develop criteria for ensuring that LTCH services are furnished only to patients who need them. Recently, t industry associations have developed and proposed criteria for LTCHs and their patient has urged CMS to work with the industry to develop criteria as we have recommended

The Commission is concerned about growth in LTCHs because we are not certain that these high-cost services are being used only for patients who need them. LTCHs are not distributed evenly across the nation but instead are clustered in certain states. Since implementation of prospective payment in October 2005, LTCHs entering the Medicare program have located in markets where LTCHs already exist. This is somewhat surprising, since facilities are presumed to be serving unusually sick patients and one expects such patie be rare. The clustering of LTCHs and the location of new facilities thus raises question about the role these facilities play. The availability of LTCHs helps acute care hospitals shorten patients' lengths of stay and reduce their costs under the inpatient PPS by discharging patients sooner than they otherwise would. This may be appropriate for ver patients who can benefit from specialized LTCH services. Indeed, MedPAC analyses h found that, when LTCH care is targeted to patients of the highest severity, the total cost comparable to similar patients using other settings. But for other patients, early dischar from acute care hospitals to LTCHs means that Medicare pays more for the total episod care. Further, this practice distorts calculations of the inpatient PPS relative weights by reducing the acute care costs and charges for the diagnosis related group.

LTCH policies, therefore, cannot be considered in isolation. Indeed, shortcomings in ot payment systems have contributed to the industry's growth. For example, Medicare's payments to acute hospitals may be inadequate for the sickest patients. This may streng incentives for acute care hospitals to discharge severely ill patients as soon as possible. recently proposed the adoption of a Medicare severity diagnosis related group classific system for acute care hospitals to better recognize severity of illness among patients. Su system may dampen the incentive for acute care hospitals to discharge patients to LTCI Similarly, flaws in Medicare's SNF payment system may make SNFs less willing to ad medically complex patients, which also increases the demand for LTCH services. This demand might be reduced by making refinements to the SNF PPS, such as those recommended by MedPAC.

LTCHs have shown themselves to be very responsive to changes in payments and shou able to accommodate cost changes in 2008. These findings, as well as the other factors Commission considers, which are almost all positive, led us to recommend in our Marc

2007 report to the Congress that the Secretary eliminate the update to payment rates for LTCH services for 2008. The Commission recommends limiting growth in payments per case until the industry and CMS agree on patient and facility criteria to better define these facilities and the patients appropriate for them.

I hope these analyses and recommendations are helpful to the Committee's deliberations, and I look forward to your questions.

Chairman STARK. Thank you. Thank you both.

Mr. Kuhn, CMS has proposed to extend the 25 percent rule for long-term care hospitals to "free standing" long-term care facilities. Have you seen evidence that acute care hospitals and free standing long-term care hospitals are developing transfer relationships that are financially beneficial to both entities?

Mr. KUHN. The issue of patient swapping has been a very big concern at the agency for the last couple of years as we've looked at this issue, and we do see a strong relationship between the primary referring hospital and ultimately the long-term care hospital and we see this in a couple of areas. One is in terms of the number of actual patients coming from the acute care hospital, the referring hospital, to the LTCH. But where we also see it is in outlier payments.

We see almost a 50 percent drop off in outlier payments for those facilities that have an LTCH or a relationship with an LTCH versus others. So I think it really raises the question with us as the agency—are we transferring patients while they're still in active treatment in an acute care hospital, and are we seeing shifting between hospitals in order to generate a second payment.

So we thought, based on the information we had, that moving the 25 percent threshold to freestanding facilities was appropriate. Now it is different than what we proposed. It's a 3 year phase in instead of all in the first year but we thought that was appropriate policy decision.

Chairman STARK. Long-term care patient and facility criteria may not diminish the need for the 25 percent rule, but will the—why don't you think it will not diminish the need for the 25 percent rule?

Mr. KUHN. Well, I don't want to prejudge the outcome in terms of what kinds of characteristics we can come up with, both facility as well as patient. One of the reasons we did, based on the comments we received, to do a 3 year phase in was to try to give us more time to look at the work that our contractor RTIs developed so we can try to synch those up at the end of the day.

So, we want to move forward with the patient characteristics, the facility characteristics research, hopefully move to an assessment instrument, see if we can move forward in that direction. I think, at the end of the day is—then we can look, is the 25 percent threshold still appropriate or does the patient characteristics take over and would help us better manage utilization?

Chairman STARK. You have—you're proceeding to implement a 75 percent inpatient rehab facility rule. Do you have any evidence on how that will affect patient access to care?

Mr. KUHN. The information we've looked at so far doesn't seem to be impactful in terms of patient access. Yes, the number of admissions in rehab facilities are down, and of course they would be. But really this is about value. This is not about volume as we move forward. The intent is really to remove the risk of Medicare overpaying for treatment for patients in these facilities. So yes, the numbers are down. But what we're seeing correspondingly is that skilled nursing facilities, home health agencies are picking up these patients in the right settings.

So, the biggest area where we had questions, that is, lower extremities or joint replacements are moving out of IRFs into other areas where they can be treated just as appropriately by the lower costs. But other patients—for maybe stroke, brain injury, nervous system problems are moving more aggressively into the rehab systems. So, this is a policy seemingly to have its impact in an appropriate way.

Chairman STARK. Thank you.

Mark, I know that you please all of the hospitals when you suggested a full update and got everybody all excited, but I gather in your testimony you're suggesting that—I'm not sure you gave us the list of who should get an update and who shouldn't. I'm waiting for you to hand me that list of the 6,000 hospitals. You had a rate of A, B, C, D, so none of the ones that get a cut are in California, I presume.

Mr. MILLER. Obviously.

Chairman STARK. Or New York or Michigan or Texas. But at any rate, is it fair to say that you recommend an update for hospitals but that there should be some differentiation to the extent we can determine that among more efficient hospitals and less efficient hospitals?

Mr. MILLER. I think that's a fair characterization of the commission's position. There's a lot of discussion around this, and you saw a lot of positive indicators, but the Medicare margins and the trends in those were disturbing commissioners. But at the same time there was a real concern that just sort of a blanket, across the board update for all hospitals was not a good use of either policy design or the resources that Medicare has. So, I think your characterization is correct.

Chairman STARK. You also recommended a 1 percent update for inpatient rehab facilities for '08. You base that on a conservative assumption about how they'd respond to the 75 percent rule. If they are nimble and able to restructure costs, how high might their margins go?

Mr. MILLER. I just want to be clear that we're in the world of estimation here. But what we estimated on different sets of assumptions was as high as five-and-a-half percent.

Chairman STARK. Under that scenario would an update that is lower than your recommendation be justified?

Mr. MILLER. I can only speculate about what the commission would have concluded, and my sense is, given where things were

in the inpatient rehab facility, they would have gone with a zero update in that circumstance. But that's my guess.

Chairman STARK. I think we'll hear from witnesses later that the inpatient rehab facilities may have to turn away patients because of the 75 percent rule and that we're seeing a decline in admissions. Should the IRFs be turning away patients? Does the drop in admissions mean there's an access problem?

Mr. MILLER. We looked at this just like Herb did as well. We decidedly see a reduction in admissions, just as Herb said. We decidedly see increases in areas like skilled nursing facilities and home health. I would characterize the commission's view of the 75 percent rule as a fairly blunt instrument, and our concerns about the 75 percent rule were to be that it needs to be dynamic, revisited, in order to be sure that it evolves with the change in care and that the process that they use to define diagnoses that are allowed should be transparent to the industry, to the patients, to clinicians.

So, we don't see—we did not conclude that there was an access problem or an issue that would warrant change at this point. We made the recommendation that we made for the 1 percent sort of evaluating the entire array of evidence.

Chairman STARK. Thank you.

Mr. Camp, would you like to go next?

Mr. CAMP. Thank you, Mr. Chairman. I think I just would like to go back to the long-term acute care hospital issue for just a second. You know, as in many areas across the country there may be only one or two acute care hospitals. There's been a lot of mergers in the medical sector. How do you propose, how does CMS propose to address an area with fewer local hospitals and will hospitals, LTCHs, located in those areas be exempt from the 25 percent rule?

Mr. KUHN. We did a couple things in the rule to try to help deal with that issue. Obviously the 25 percent rule is there for hospitals, but in two instances, if they're located in the rural area the threshold is 50 percent or if they happen to be a dominant facility in the area it can go up to 50 percent as well. The second part is that if a patient from an acute care facility has already triggered an outlier payment that doesn't count against the 50 percent threshold, or if they're receiving patients from someone's home or a skilled nursing facility or something like that. So, we think those changes provide the flexibility—enough flexibility in those areas.

Mr. CAMP. You often don't have hospitals. You have hospital systems. Are hospitals within the hospital system treated as distinct hospitals or because they have the same parent are they all part of the same hospital?

Mr. KUHN. My recollection, it's treated as a system for that process, but I could double check. I believe if I'm incorrect we could get back to you in writing on that one.

Mr. CAMP. I also want to just also touch on the CMS 2.4 percent reduction for hospitals. I guess what MedPAC giveth CMS taketh away. I realize there are significant changes being made to the DRG system, taking into account patient severity. How did CMS come up with this 2.4 percent reduction in payment for coding and can you explain how CMS proposes to implement that?

Mr. KUHN. Sure. First of all, it really is not a reduction. It's a budget-neutral adjustment. The issue, if you really look at this

year's rule, hospital payments are going up by an excess of $3 billion. It's a 3.3 percent market basket update.

What we've done in this proposed rule is the third year in terms of adjustments on severity, and we're increasing the number of DRGs from approximately 538 to 745. When you do that, hospitals—and as I said in my opening statement, will code more accurately. As a result of that, you want to keep it budget neutral throughout the system. You don't want to spend more money by virtue of these additional DRGs, you want to spend the same amount of money, so you need to make a budget neutral adjustment.

This is supported by over 20 years of research and experience in this area. When the PPS system for hospitals was first implemented in 1983 there was a behavioral adjustment put in place. In a retrospective manner it looked like the agency undershot and hospitals coded more aggressively than we originally thought.

If you look at long-term care hospitals, psychiatric facilities, rehab facilities, all those were also put in prospective adjustments for behavioral changes. At least for long-term care hospitals and rehab facilities, the evidence shows that we undershot and we've had to go back and make retrospective changes.

So, this is standard behavior in prospective payment systems and what we do. Where we got the numbers that we put in place were based on experience that we saw with the state of Maryland. Maryland operates under a waiver and they put in place the APRs, the all-payer refined DRGs, a few years ago, and we saw very aggressive coding changes as a result and in direct reaction to these new DRGs that were put in place.

So based on the best information we had for Maryland our actuaries made these recommendations. But again, it's a proposed rule and we hope to get comments from the stakeholder community on it.

Mr. CAMP. I'm sure you'll be receiving many of those. Just one last question, Mr. Kuhn. Regarding home health, obviously the Deficit Reduction Act tied home health payments to the reporting of quality measures and if you reported quality you received a higher payment, but CMS also required that home health agencies submit OASIS data in order to receive that higher update.

Obviously this is something they were required to do anyway. I am encouraged that CMS is proposing to capture two additional measures relating to wound care next year, but does CMS really feel that it's getting enough useful information out of the OASIS data? Since payment is tied to the reporting of quality data, does it make sense to require agencies to submit something that they aren't required to submit as a condition of participation in the Medicare program?

Mr. KUHN. It's a very good question, and you're right. We have 10 data elements we're using this year and we plan to go to 12 for next year. We do need more major development in the home health area. The time being from when the legislation was passed to the implementation of this was very short and so we had to kind of go with what we had, but there is a duplication between what's reported on OASIS and what's reported for the quality indicators. But major development is underway and we hope in future years

we can get a more expanded list and achieve the objective you all wanted in the legislation that's better quality information that both patients and providers can use and that ultimately may be tied to payment someday in the future.

Mr. CAMP. All right. Thank you. Thank you both for your testimony. I see my time has expired. Thank you, Mr. Chairman.

Chairman STARK. Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Thank you, Mr. Chairman, and thank you gentlemen for your testimony. Mr. Kuhn if I could first address your attention to the monetary cap on therapy services under Part B in skilled nursing homes. As you know, we have the exceptions process. It's set to expire at the end of the year. What will happen to people who have life threatening conditions if they bump up against that cap and we don't extend the exceptions process?

Mr. KUHN. If the exceptions process is not extended for this year it could create some real issues in terms of people as you indicated, bumped up against the cap. So I think this is something that's real ripe for us as the agency to engage with all of you to think about what should be the future policy. Should it be an extension of the cap or is there another way that we can structure this payment system to help in that effort?

Last year we took possession of three reports we got from contractors in terms of therapy adjustments we could make, adjustments in the payment system. We posted all those to our website and we put it out for everybody to see. Then beginning this year we started calling in the stakeholder community to talk to them about those reports and what we could do together with them to come up with some ideas in order to engage you and others about the right way to go.

So, I guess the question is, is there enough time yet this year to still develop some proposals that we could do something different than the current exception process or do we need to extent the exception process, or the third option is to let the caps go into place as they were first put in place as part of the BBA. All those are options and we'd like to talk with you and others in Congress more about that.

Mr. DOGGETT. Well, if we let the caps go into place there will be some pretty severe impacts on individuals with disabling conditions, especially in rural areas, won't there?

Mr. KUHN. I have no doubt that we would see some information. One of the things that maybe we—could be helpful to you and others is to understand kind of the time frame at which people start to hit the caps because people with real chronic issues might start hitting those caps by, say, the end of February of next year. Some it might be, you know, in the summer. We don't yet know.

So, I think some better data mining on our part could help you all in terms of that decision-making process.

Chairman STARK. Since we're almost to the midpoint of this year, do you have a proposal to advance at this point as an alternative to the exceptions approach?

Mr. KUHN. Nothing specific yet other than what we have in those contract reports and our discussions with the stakeholder community. But again, I think this is something that we all could work together on and talk further about.

Mr. DOGGETT. Of course it unfortunately is true, is it not, that the Administration did not put in any money in its budget for correcting the therapy caps under any proposal?

Mr. KUHN. There was no recommendation in this year's President's Budget, that's correct.

Mr. DOGGETT. As far as this year's President's Budget is concerned as well, do you agree with the chief actuary of Medicare who has estimated that overpayments, as the Chairman said in his opening statement to Medicare Advantage shortened the solvency of the Part A trust fund by 2 years?

Mr. KUHN. I guess the way I would characterize it, not as an overpayment but the opportunity to pay for additional benefits for those in Medicare Advantage. I would not dispute the information provided by Rick Foster that if you change the payment rates or rate reductions in Medicare Advantage it could extend the trust fund for an additional 2 years. However, the provisions put in the President's Budget for changes in Medicare policy would extend the trust fund for an additional 4 years.

Mr. DOGGETT. Well, some of those are fairly—have fairly onerous consequences of doing that. You indicate that the President put in no money to help my constituent who has a head injury or lung disease and bumps up against the exceptions under Part B in a skilled nursing home, and yet, as I understand his budget he rules off limits taking even a dime from Medicare Advantage.

Mr. KUHN. That's correct. There are no recommendations for changes in Medicare Advantage payments in the President's Budget.

Mr. DOGGETT. Is that still the Administration's position that we are to look at Medicare and the many conflicting concerns and interests that we have but we're to do all of it without taking a dime from the Medicare Advantage program?

Mr. KUHN. Again, there's no recommendations in the President's on Medicare Advantage. But having said that we are continuing to look at the Medicare Advantage program and changes are in the offing.

This year because we are making changes in fee-for-service, that also impacts Medicare Advantage. So this year's proposal dealt with issues such as the frailty adjustment, to make sure that those adjustments were made accordingly, fee for service normalization and ESRD changes. So, there are changes that are ongoing with the payment system on Medicare Advantage as part of the regular regulatory process.

Mr. DOGGETT. Finally with regard to long-term care facilities, you've had a couple of questions on this. As Dr. Miller pointed out, MedPAC made recommendations back in 2004, almost 3 years ago, to have you set up a facility and patient criteria system. When will we get it?

Mr. KUHN. That's a very good point. Basically MedPAC did make that recommendation and acting upon that we engaged the contractor RTI to give us a report on this. That report was made available late last year. Already we have convened one technical expert panel with the industry to help us kind of look at the report, come up with a set of recommendations.

Very soon we ought to be convening a second technical expert panel to help us move forward on that, and then the really hard work begins in terms of the development of assessment instruments. I would hope within the next couple years we could be at a better place here but probably not before then.

Mr. DOGGETT. You think a couple of years before a new regulation is in place?

Mr. KUHN. A couple of years before we would have some good, solid recommendations on a new kind of classification system for LTCH.

Mr. DOGGETT. A couple of years before you make the recommendation, not before it becomes effective?

Mr. KUHN. That's right, a couple years before we'd have a final recommendation.

Mr. DOGGETT. As far as where you are now, you said you brought in some experts. Has MedPAC, Dr. Miller had a chance to see and comment on the alternatives that you're looking at?

Mr. KUHN. They will be engaged in that process as we go forward, yes, sir.

Mr. DOGGETT. But they have not thus far? Are you members of the——

Mr. KUHN [continuing]. I can't remember if they were on the technical expert panel or not.

Mr. MILLER. I believe that we were briefed on the directions that they were going in, yes.

Mr. DOGGETT. We would certainly need your further input on that. It's been a very long process.

Mr. MILLER. The only thing I would point out is that there's actually two different pieces of legislation floating around from the two different associations in long-term care hospitals, which take pieces of our criteria and build them into legislation. I would also suggest that we start looking at that and think of one piece of legislation that encompasses all of the criteria and use that as a place to start our discussions.

Mr. DOGGETT. I'll just follow up on that. Is there one of those approaches that you find preferable to the other?

Mr. MILLER. No, what the industry did is they sort of selected pieces of our criteria and kind of pulled them apart and put them in two different bills. We think there needs to be both patient and facility criteria, and we have our list, and we think that the legislation needs to include all of it.

Mr. DOGGETT. Do we need to move forward in passing that legislation rather than waiting for another couple of years for them to come out with a recommendation?

Mr. MILLER. I mean I think ultimately—and actually I'm not sure of this. I think ultimately there may need to be some legislation in order for the industry to—or for the agency to go forward, although I'm not sure of that.

Mr. DOGGETT. What's your view on that, Mr. Kuhn?

Mr. KUHN. We haven't taken an official position on any of the legislation that's out there. It does, for example, exclude psychiatric and rehabilitation cases from going into LTCHs, but on the rest of the area, really getting the good, scientific basis in terms of how you make an assessment of when someone is ready to be trans-

ferred from an acute care hospital to an LTCH. I just don't know if we're there yet on the body of evidence.

So, legislation could get us part way there. I just don't know if it would get us all the way there yet.

Chairman STARK. Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman. You know, I liked the question Mr. Doggett asked about how you're developing a patient assessment tool. I don't think you really answered the question, when's it going to happen. You're telling us maybe one, maybe 2 years.

Mr. KUHN. It's probably still a lot of research and a lot of development needs to go on, Mr. Johnson, and we're probably 2 years out from the final effort in this area.

Mr. JOHNSON. Well, that brings me to another question. It seems silly to me that we're using outdated data. I've been after you guys about that before. But in home health care I think you went from '97 to '04, but '04 is still 3 years old. You know, we send patients to doctors, and I think doctors are more reliable on making decisions about where a patient ought to go or how long he ought to stay. Their information is current. I mean it's of the minute. So, why can't we get that kind of information and use it in our assessments?

Mr. KUHN. I agree having the best information available for payment systems is absolutely key. Part of it is that the hospitals and other providers that provide us their information provide a report at the end of the year. It needs to be audited. Then if there's any disputes in it they need to go through that process. So, the whole back end process of auditing, making sure it's accurate takes time to play that out. If there's ways that we could accelerate that and use better, more current information we would certainly like to find a way, but at least at the time being it looks like it's about as fast as we can move on the data for payment systems.

Having said that, in terms of clinical information, now that we're moving for paper reporting and some of those issues the data is turning around a lot quicker. So we're doing better on that and we seem to be able to move that one because you don't have to go through the extensive financial audits. So, on that side of the ledger I think we're going to have a better picture in the future.

Mr. JOHNSON. Would it help if hospitals got everything on computer and talked to each other?

Mr. KUHN. Most of it is electronic now, and our cost reports are standardized. They seem to be able to get the information in accurately and appropriately, but additional standardization in a number of areas probably would help as well.

Mr. JOHNSON. You indicate, I believe, you announce that free standing, long-term health care would be subject to the 25 percent rule. Yet, in areas across our country communities have only one or two acute care hospitals. How is the CMS proposing to address areas with three or fewer hospitals, and will long-term care in these areas be exempted?

Mr. KUHN. What we're trying to do in that area is a couple of different thresholds. One is to make sure for the rural long-term care hospitals, they're set at a 50 percent threshold, so they're not held to the 25 percent threshold. Then also those areas like you de-

scribed where there's kind of a dominant player in the area, and say there's two institutions, one could be at the 50 percent threshold, the other could be, say, at a 40 percent. So, we think between the combination of both the dominant and the rural kind of set asides, I think it works in those areas and I think it makes a better policy.

Obviously this is something we want to monitor as we do implementation. We're going to do a 3-year phase in. The idea of a 3-year phase in was to deal with the first question you asked to make sure that you kind of synch this up at the end of the day with a better classification system so that it will be one for active monitoring for all of us.

Mr. JOHNSON. Mr. Chairman, I don't have any further questions. Thank you.

Chairman STARK. Thank you. Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman. Mr. Kuhn, in regard to the proposed rule, the IPPS rule, as I understand it, the adoption of the cost-based weights might result in an increase to rural facilities but that the shift to the severity-based DRG will certainly result in a decrease. I believe your staff has conceded that this proposal will bring about a net decrease in reimbursements to rural hospitals. I'm interested to know if you have any way to quantify the severity of the cut that the rural hospitals will experience. Has there been given any thought to providing some sort of carve out for the rurals or hold harmless for the rurals?

Mr. KUHN. What you're describing, you described it accurately. What happened was is when we did the cost-based weights last year that really did send payments away from surgical procedures more to medical procedures. Real hospitals, by kind of a generalization tent to treat more medical cases than surgical cases, so they were the beneficiary of the changes made last year as part of the process.

But last year when we laid out the proposal and as we talked about the proposal this year, when you go to severity adjustments it tends to have the reverse effect. Urban hospitals tend to see sicker patients and probably ought to be awarded accordingly as a result of the——

Mr. THOMPSON. I'm pretty familiar with the reasoning. I'm just wondering, have you been able to quantify what the hit is going to be to rural?

Mr. KUHN [continuing]. I think the ultimate impact for rural hospitals over is a minus 1.5, maybe a minus 2 percent overall, a general characterization of rural hospitals.

Mr. THOMPSON. So, have you thought about doing a hold harmless or provide some sort of—I don't think anybody in this room thinks that rural hospitals are fat and sassy. They're experiencing the same problems and maybe greater problems in other areas. It seems to me that this proposal would make things even more difficult for people who live in rural areas to get the type of medical care they need.

Mr. KUHN. Now I think that's a fair point. That's not a specific proposal we made and we put forward. Having said that, what we could do is receive comments on it for people to give us comments

in terms of ways that we could look at that. So, we're certainly open to hear any comments people might make.

Mr. THOMPSON. Is it appropriate for me to ask you to give us some information on that or give us some thoughts?

Mr. KUHN. We would be happy to come and talk to you and your staff at a later time about that if that would be helpful, happy to.

Mr. THOMPSON. Thank you. My next question is regarding the recovery audit contractors that are used. I understand that these contractors are able to retain a pretty hefty percentage of recovered payments. Some of my hospitals tell me that there's one particular state contractor, PRG Schultz working in California, that they're denying reimbursements for almost all joint replacements, and these are ones that are done in IRFs. My question is if they go through the appeal process and they're found to—and that reduction is overridden, will that money be reclaimed from the contractors?

Mr. KUHN. Yes. We have these RACs, the recovery audit contractors, that are operating right now in three states, California, New York and Florida. You're right, the one in California has been active in looking at payment options in terms of rehab facilities. Right now they are looking at single joint replacement issues, things like that.

We've talked extensively to California Hospital Association. I think you and others have directed them to us to talk about this issue. Right now, from understanding it's that if the hospitals have appealed the determinations by the RACs none of them have been upheld in appeal—or they've all been upheld, none have been overturned. However if they are overturned of course, the dollars do flow back to the hospital.

Mr. THOMPSON. It would come back from the contractor?

Mr. KUHN. That's my understanding, yes. If I'm incorrect, we can correct that for you for the record, but that's my understanding.

Mr. THOMPSON. Thank you. One final question. That's the cuts to capital payments, and some hospitals—and I hate to continue to be parochial about this, but California hospitals have put a lot of money in regard to safety issues, specifically seismic safety. My understanding is that this particular proposal would come down pretty hard on the efforts in California to protect patients from troubles that would come about if there were seismic incidents that would affect these hospitals.

Mr. KUHN. I am aware of the seismic issues California hospitals have, and I think that would be a good thing for us to get a comment from the hospitals of California and others as we think about it.

The other thing to point out about the capital recommendations we make in the proposed rule, and going back to your concerns about rural issues is that for the recommendations the only changes we made or the only recommendations we're making impact urban hospitals. For rural hospitals we say leave them alone on capital, give them the full update in that regard. So, it really—the differentiation is between urban and rural.

Mr. THOMPSON. Well, urban and rural differences notwithstanding, California hospitals, the money that they need to retrofit their hospitals is more than the equity in all the hospitals in California combined. So, it's a huge issue, and I know it's a state mandate to require the seismic retrofit, but I don't think anybody at the Federal level is interested in putting patients in an unsafe situation.

Thank you.

Chairman STARK. Mr. Ramstad, I'm—we're crowding toward the end of the vote here. I would hope that we could ask you both to stay as we've got five votes. It will take us the better part of a half—45 minutes, but if it's possible we'd sure appreciate either or both of you staying.

Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman. I'll be as succinct as possible. I thank you, Dr. Miller and Mr. Kuhn, for being here, and I appreciate certainly the fiscal challenges that Medicare is facing. I agree that changes obviously need to be made. One of the concerns I hear time and time again is that we can't cut Medicare because Medicare payments compensate for low Medicaid reimbursements. Isn't it true that cross subsidization is a big deal, a major issue, especially for providers like long-term care facilities that typically see a large number of Medicaid patients, caseloads are dominated by Medicaid patients? I want to know, number one, how major is the cross subsidization issue and number two whether CMS is working with the states and providers to develop a system where Medicare pays for Medicare services and Medicaid pays for Medicaid services. That seems to make only good sense.

Mr. KUHN. That's a fair question. I think the most recent data I've seen on this and probably Mark Miller has probably better information than me right now, is that at least for a typical long-term care hospital, about 10 percent of their patient load is Medicare Part A stays, but it represents about 20 percent of their revenues. So I think it makes the point you were talking about right there, there is a lot of cross subsidization going on there.

Medicare itself works a lot with states in terms of their state plans to make sure that they're appropriate and adequate in terms of their payment systems. But again, states have a great deal of leeway in terms of their ability and their determinations in terms of setting rates under the Medicaid program. But that happens not only with long-term care providers but other providers in the Medicaid program as well.

Mr. MILLER. We've addressed this issue a couple of times. This comes up all the time, as you might imagine, and our concerns here are that first of all, using a small block of dollars to subsidize the larger block, the targeting is wrong. Facilities that have more Medicare would get more payments. Then finally you'd basically be inviting the states to step back in their responsibilities and so we think that this is really a problem.

Mr. RAMSTAD. Thank you.

Chairman STARK. Thank you [continuing]. We'll recess subject to the call of the Chair.

[Recess.]

Chairman STARK. I thank the witnesses and our guests for their patience. Mr. Hulshof will inquire.

Mr. HULSHOF. Thank you, Mr. Chairman. I ask permission. I've got an extended written statement. May I include it as part of the record?

Chairman STARK. Without objection.

Mr. HULSHOF. Thank you, sir.

[The information follows:]

Opening Statement of Representative Kenny Hulshof
Committee on Ways and Means, Subcommittee on Health
May 15, 2007

Mr. Chairman, I'm grateful that you have called this hearing. Fee-for-Service Medicare financing is one of the most pressing responsibilities of this Committee, and how beneficiaries receive treatment within the post-acute care setting is a vital piece of inpatient care.

As you know, Mr. Tanner and I have introduced legislation, H.R. 1459, which addresses post-acute care in the Inpatient Rehabilitation Hospital, or IRF, setting. In recognizing that IRF admissions goals hoped for in drafting the so-called 75% Rule have been achieved, H.R. 1459 keeps that rule at the current 60% threshold. As of today the bill has 151 cosponsors, and we're adding cosponsors every day

Our biggest concern about the 75% rule is the seemingly arbitrary effect it has on patients, specifically patients who are not within the 13 diagnostic categories that "count" toward the 75%, including cardiac, pulmonary, cancer, pain, and joint replacement. Patients outside the 13 qualifying conditions are often denied IRF access, and access is most restrictive for patients whose needs benefit from

newer rehab specialties such as pulmonary, cardiac and cancer.

A Moran Report published this month demonstrates the precipitous drop already seen in the IRF setting: in the four quarters ending in Quarter 1 of 2007, Medicare volume totaled 255,006, down 23.5% from the 333,559 discharges in the same period ending in Quarter 1 of 2004. That's almost 80,000 reduction in discharges in 3 years. The admissions criteria rule has achieved its goal, and it needs to be maintained at 60%, or we risk doing irreparable harm to constituent access to inpatient rehab.

Mr. Chairman, for all these reasons, we need to be paying close attention to what's happening with the 75% Rule. 2 years ago, we held a similar hearing and heard from CMS, from Mr. Kuhn, and I look forward to the update we will hear from him today. It was discussed at that hearing 2 years ago that the rule's impact on access may have been overstated, because the "high-water mark" where a spike in admissions to rehabilitation hospitals had occurred due to the suspension of the old 75% Rule. But in the past 2 years the 75% Rule produced a fairly harsh picture, both for rehabilitation hospitals and for patients who have rehabilitative care needs: we're seeing patient case declines in rehabilitation hospitals in the

neighborhood of 20% or more, not basing it on the "high-water mark."

If this rule remains on its current trajectory toward the 75% threshold, and the comorbidities policy disappears – and by the way, I think CMS needs to carefully evaluate its decision in the FY '08 IRF PPS proposed rule to discontinue comorbidity cases as compliant cases – I'm concerned we're going to see a situation where many people who need and deserve inpatient rehabilitation aren't going to get it.

Mr. Chairman, I'm not comfortable with the 75% [illegible] years ago in our post-acute care hearing I said we need to move toward a system that places more emphasis on the specific functional and medical aspects of patients. I still believe that. But, that is going to take research; that is going to require some resource expenditure; and it is going to require people who think their mousetrap is the best mousetrap and nothing else will do, to be open-minded to change – all of which is another way of saying it is going to take some time to get there.

Until we get there, though, the 75% Rule will still be with us. And so we need to really ask ourselves if we are comfortable with leaving it on a trajectory toward full implementation. Keep in mind, Congress

assumed jurisdiction over half this rule – its percentage threshold – when we extended the 60% threshold by an additional year in the DRA. Even if CMS wanted to, it can't alter that threshold percentage – it is a matter of legislative law, not regulation. So we have a role here.

Mr. Tanner and I have introduced H.R.1459 – not to repeal the rule; not to turn back the clock and lower the threshold percentage; not to expand it or otherwise modify it – but to simply keep it where it is. And let's make no mistake about it: where this rule is, is keeping rehabilitation hospitals on their toes and watching who they're admitting like they never have before. I think the position that Mr. Tanner and I have taken in H.R. 1459 is a balanced approach that will allow CMS's policy aims in this area to continue being achieved in a reasonable fashion.

This hearing is an important one, as we're looking to determine our priorities and objectives to deal with Medicare Part A this year. It is my hope that to the extent this Subcommittee, and the full Committee, may report a bill addressing Part A, we will include H.R.1459's provisions in that report.

Mr. HULSHOF. I, too, want to thank both you gentleman for sticking around. Mr. Chairman, this past Saturday, I was the commencement speaker at the University of Missouri School of Health Professions. This was the new group going into physical and occupational therapy, speech pathologists, and the theme of my remarks was what were you thinking? It actually was quite inspiring, Mr. Kuhn. I see you smiling at me. But it was—I got their attention when we went into it.

What I want to do is, is I want to talk a little bit about and follow up on what each of you has said regarding the 85 percent rule. You know, one of my biggest concerns, and Dr. Miller, you said, and I absolutely agree, we need a dynamic way of looking at reimbursements. I think the goal that we share that you have as well is an integrated post-acute care system.

But I've got to tell you that one of my concerns about the 75 percent rule is the seemingly arbitrary effect it has on patients, specifically those not within the 13 diagnostic categories that count toward the 75 percent rule, including cardiac, pulmonary, cancer pain, joint replacement. So then patients that fall outside those 13 qualifying conditions are often denied access at an inpatient facility. Access is most restrictive for patients whose needs benefit from these newer rehab specialties, especially pulmonary and cardiac and cancer.

I don't know if either of you have seen the Moran report that came out earlier this month. It basically says if you look at the drop in—as far as discharges from March 31st of 2004 compared to March 31st of 2007, so a three-year period of time, we have seen a nearly 80,000 reduction in discharges. That's a 23.5-percent decline. Now, Mr. Kuhn, you said, and I'm not—this is not an indictment of what you said, but you said this is the intended impact. I mean, the whole idea of providing this integrated care.

Yet I've got to tell you that, you know, 2 years ago, you may recall, Mr. Kuhn, you and I, we had a similar discussion, and you mentioned that, well, there was a high water mark because there was a spike in admissions because we had suspended the old 75 percent rule. But I've got to tell you, looking back over the last couple of years, you know, this is a fairly harsh picture. Dr. Miller called it a blunt instrument, and I couldn't agree more.

So if we have achieved the intention—I mean, if the intent has now been realized, why don't we stop where we are? Mr. Tanner and I, and I know he wasn't able to return, but we have a bill. H.R. 1459, that basically recognizes that we've achieved those admission goals we had hoped for in drafting the 75 percent rule, and we maintain the 60 percent threshold from here on out. You know, we're not repealing it. We're just—we're standing pat with that. I would hope—I'm not going to ask you to comment on the bill specifically.

But let me ask you, Mr. Kuhn, 2 years ago when we discussed the 75 percent rule, a lot of your prepared testimony back then focused on the need for research. You said research was an important next step. Since then, what research has CMS done or what has CMS looked at to more appropriately identify the types of clinical or functional or medical characteristics that could be used to refine the 75 percent rule if we keep it in place?

Mr. KUHN. I would agree with you, Mr. Hulshof, that indeed, research is the way we need to go in this area. A couple of things that we've done in this area, first, right after we came out with the final rule back in 2004, we worked with the National Institutes of Health to convene a panel to help us talk about a research agenda and what would be the right way to go.

As a result of that, we had an information notice to investigators that was posted last year by NIH in collaboration with us that talked really about the need for a research agenda for rehabilitative care, and the fact that how we can increase the base of knowledge of information that's out there, and how CMS could work with researchers to help them design their studies, how we could find ways through our clinical research policy to make sure that Medicare would pay for the patients in these studies, all the things that we could do to the maximum extent possible.

To be quite candid, we haven't seen anything come forward yet as a result of that. We've had some general inquiries but no specific proposals yet on that agenda. But we want to continue in that area.

Having said that, NIH convened another panel just a month ago to talk further about a research agenda which we participated in and encouraged as part of that process. Also, we've had some good outreach with the industry themselves, with specific rehabilitative hospitals and others who are trying to conduct some research. So, we're probably not as far along as we would probably like to be, but we are making progress in that area.

Mr. HULSHOF. I appreciate it. As my final comment, Mr. Chairman, thank you. I won't ask you a question, Mr. Kuhn, but I'm concerned about CMS' proposal not to allow co-morbidity cases to be calculated. It's been counted for the past 3 years. Starting next year, it won't. If you don't mind, I'll submit a question to you and we can chat about this further.

Mr. KUHN. We'd be happy to chat with you further about that, and we hope to get comments during the comment period on that specific issue. So, that would be helpful to hear more from you about that.

Mr. HULSHOF. Thank you. Thank you, Mr. Chairman.

Mr. MILLER. Could I add one thing to this?

Mr. HULSHOF. Please.

Mr. MILLER. You know, when the rule initially came out a few years back, and this I think just illustrates how difficult the problem is, we got a group of clinicians together and sort of talked about the implications in it. There was a lot of comments that you might imagine along the lines that you were saying. But there was also a clinician who said, actually—and we were talking about hip and knee replacement, that type of thing. There was also a clinician who said I don't use the facilities at all. I have a protocol where I send my patients through exercise, get them ready for the operation and then use strictly outpatient therapy and home health—or home setting in order to get them rehabbed.

I think that points to the need that Herb is pointing out, and I think you're pointing out, that we just lack a lot of clinical information about what is needed for one situation versus another, and rehab is really a complicated area. Something that the commission

is going to call for in its June report—we've talked about it public, but it will be out next month—is to develop comparative effectiveness information to try and address this as well as other types of issues where you get these complications.

Chairman STARK. Thank you. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Mr. Chairman, the line of inquiry I have has largely been covered earlier, but I've got a couple of things to say about it. This involves the LTCH limitation. Mr. Kuhn, I would just say how disappointed I am representing two LTCHs in North Dakota. Each would have had substantial trouble with the initial 25 percent proposal, and even 50 percent in rural areas from one referring source.

Just the dynamics of health care in rural areas render this very crude cost containment instrument somewhat inequitable in its application. I mean, we have dominant medical facilities that have relationships with these LTCH's for ventilator weaning, for wound closure. In light of the nature of utilization patterns, you're going to have these major hospitals being a major referral source.

So, to have all this time go by and not really get to the crux of the issue, which is an evaluation of the particular patient, the severity of health conditions that they're dealing with, the kind of care required for that patient, seems to me that you spend an awful lot of time going nowhere on getting an appropriate handle on this, even though the MedPAC recommendation is now I think 3 years in the state.

I'd like you to clarify for me—you talked about it a bit with the earlier questions, but do you intend to come down on a patient-based criteria for the appropriateness of LTCH funding, and if so, when?

Mr. KUHN. You're right. It is our intent to move forward on a way to better classify not only the patients but the facilities as well, at least some recommendations for doing that. If you look at it right now, an LTCH, the only classification we have is that it's an acute care hospital with an average length of stay of 25 days or more. So what MedPAC opined on back in 2004, what we've moved forward with a contractor to get a report, which is out there, and we've already convened one technical expert panel, is now to take that information and what can we use for classification for both patients as well as facilities.

Our best guess right now in terms of a research agenda to continue that forward is probably a 2-year window still is the best we can think of now. Would we like to do it sooner and faster? You bet. But at least that's kind of our current expectation of where we think the next steps are.

Mr. POMEROY. Do you believe Congress then should hold in abeyance its own thoughts on this matter until this period has run its course, or move some of the legislation that's been pending?

Mr. KUHN. You know, that's a tough question to answer, because I don't want to prejudge the research in any way, shape or form, but, obviously, if Congress wants to move forward with its own agenda, you know, that's certainly their prerogative.

I think we have some good information out there. I think the work of our first technical expert panel, we hope to convene a sec-

ond one here very soon, hopefully will give us the information that we need to move forward on.

So, you know, this is hard for me to say here, you know, trust us. But I'd like us to be able to see how much further we can get before Congress wants to legislate in this area and hold us accountable for taking the next proper steps to move forward on a——

Mr. POMEROY. What time does your rule—when does your rule take effect?

Mr. KUHN [continuing]. It is effective July 1. The final was published about May 1, and it's effective on July 1. What we have in that rule is kind of a 3-year transition on the 25 percent rule, and a chance for us to sync up the final classification somewhere, you know, in 2009, something like that.

Mr. POMEROY. I'm sorry. I'm not quite sure I understood that part.

Mr. KUHN. Yeah. What we did in the final rule, when we put the proposal out, we said we would do—our recommendation was to move to a 25 percent threshold immediately for free-standing LTCHs. But after the comment period and listening to the comments we received, we said let's do it over a 3-year transition. So, it would be 75 percent beginning on July 1, then move to 50 percent, and then ultimately 25 percent in the third year.

That bought us, you know, 3 years to kind of work on this classification system because the issue is, is the classification a more appropriate system, or is the 25 percent rule more appropriate? So that kind of brings them both together so we can evaluate which one works best——

Mr. POMEROY. I could almost tell you right now. What could be better than patient assessment? This involves reimbursing medical care delivered per patient.

Mr. KUHN [continuing]. Right.

Mr. POMEROY. How can you do better than per patient certification?

Mr. KUHN. I agree patient assessment—perhaps Mark has some things to add about it, but, you know, the real crux of this issue, because these facilities are both acute care hospitals, one just has to have a longer length of stay, at what time do you stop active treatment in an acute care hospital and start treatment in an LTCH? How do you assess that? That's a tough clinical question that people need to work on, that we all need to work on as we go forward. But Mark might have some ideas on that, too.

Mr. MILLER. I mean, just—when we went through and did this analysis, and our analysis was based on data as well as going out and talking to clinicians that worked in the long-term care hospitals, we acknowledged at the end of our report that even with a revised classification system for long-term care hospitals, patient and facility, there are still seams between the inpatient PPS system and the long-term care hospital where, I mean, for example, you can literally take a patient out of one part of the hospital, move him to another, and move him into a different payment system. I know you know this.

So we said that there would still be issues that have to be worked through to kind of make sure that these two payment systems are calibrated to work with each other. We still would like to

see the patient and facility criteria move along. But I'm not sure that it will come—and we think it will make the situation better. I'm not sure it will eliminate the issue entirely.

Mr. POMEROY. I do, Mr. Chairman, and I know my time has expired——

Chairman STARK. Go ahead.

Mr. POMEROY [continuing]. I think that they were—I like the changes to the rule better than I like the initial rule. I thought the initial rule was horrible. Now I think what they're moving forward with is merely bad.

[Laughter.]

Mr. POMEROY. It could be better. I do think that at least Congress will have the chance to act before the—some of the outyears kick in. Thank you, Mr. Chairman. I yield back.

Chairman STARK. Thank you both. Thank you for your patience as we went off and voted on some very seriously important legislation. We'll, I'm sure, be talking with both of you again more as we proceed and try and find answers to these questions.

We now have an exciting panel who have all come here today to volunteer to give back money to Medicare, because they all feel they're being overpaid.

[Laughter.]

Chairman STARK. They're here to support the Medicare Advantage program. I'm just so thrilled that the Federation of American Hospitals has sent Mr. Chip Kahn to counsel with us. The American Hospital Association has sent its President and CEO, Mr. Umbdenstock. The American Health Care Association sent its President, Bruce Yarwood. The American Association of Medical Colleges and the Greater New York Hospital Association has sent Mr. Stanley Brezenoff. The National Association for Home Care and Hospice and the Michigan Home Health Association has sent someone Mr. Camp would like to introduce.

Mr. CAMP. Well, thank you, Mr. Chairman. I appreciate the opportunity to introduce Christine Chesny, President of the MidMichigan Visiting Nurses Association from my hometown of Midland, Michigan. I've known Chris for many years. We've visited over the years on home health issues, and particular on home health agencies in Michigan. She's been an effective leader and advocate, and I welcome her to the Committee and look forward to her testimony today. I know it will be informative.

Thank you very much, Mr. Chairman. I yield back.

Chairman STARK. Thank you. Dr. Mary Beth on behalf of the American Medical Rehabilitation Providers Association is our cleanup batter today.

Chip, lead off.

STATEMENT OF CHARLES N. KAHN III, PRESIDENT, FEDERATION OF AMERICAN HOSPITALS

Mr. KAHN. Thank you, Mr. Chairman and other Members of the Subcommittee. I appreciate the opportunity to appear here today to discuss Medicare policy on behalf of the Federation of American Hospitals, the nation's investor-owned hospitals.

While Medicare has successfully protected America's seniors and disabled for many decades, the program frequently challenges the

hospitals that its beneficiaries depend on for care. I will cover today five of those challenges.

First, CMS proposes a payment rule for FY08 that cuts Medicare payments by some $25 billion. This proposal comes as MedPAC estimates overall Medicare—hospital Medicare margins at negative 4.5 percent for 2007, and so recommends a full market basket for hospitals for FY08. The CMS reg ignores the deteriorating Medicare hospital fiscal condition, and what is particularly frustrating is that the proposal is based on questionable analysis.

Most of the cuts occur because CMS has decided to make the DRG system more sensitive to patient severity. CMS has paired the refinement with cuts in payments based on the assumption that hospitals will reap some kind of financial windfall from the effects of this policy change. Our analytical work has yet to reveal a credible basis for what amounts to an overall payment reduction of 4.8 percent over the next 2 years.

Additionally, CMS proposes to cut hospital capital payments. The justification for these cuts are based on an analysis by CMS that covers 1996 to 2004. What hospitals experienced in 1996 is hardly relevant today, and in 2004, the Medicare hospital capital margins dropped to their lowest point, 5.1 percent, which is 34 percent below 2003, and extending that trendline further, capital margins today could easily be negative and are part of the negative bottom line on Medicare which is shown by MedPAC. Hospitals need relief from these CMS cuts.

Second, these very cuts result from payment reforms that CMS would institute in response to problems identified with physician-owned specialty hospitals, while the Administration has failed to properly exercise its authority to apply the Stark rule in this regard. Yes, the CMS proposal will cut payments. But it will utterly fail to address the perverse economic fundamentals of self-referral and ownership on which the physician-owned pseudo hospitals operate. Payment changes will never resolve the conflict of interest inherent in this type of ownership and referral that is so disruptive in our health care system.

CMS's action fails to eliminate the incentive for facilities to increase utilization, to avoid Medicaid and uninsured patients, to divert to their own facilities well-insured and healthier private pay patients, to avoid emergency room and on-call obligations, or even to continue to engage in careful selection of Medicare patients. We strongly urge the Congress this year to permanently ban self-referral to these facilities.

Third, public reporting of quality and performance metrics can lead both to improved care and better informed patient consumers. There is strong evidence that the reporting of the Hospital Quality Alliance, HQA, measures is making a difference. We recommend both reinforcing HQA's contributions and putting in place a national quality improvement agenda through expanding the role of the National Quality Forum to serve as the priority setter for the advancement of clinical performance metrics and as metric overseer.

Congressional support is essential here whether you proceed with pay-for-performance or continue the current course of measurement and transparency.

Fourth, while there is always a need for examination of the role of providers in the post-acute continuum, CMS has adopted arbitrary regulations in this area that we believe fail the patients. In one case, the 75 percent rule rehab hospitals, not yet fully implement, it has already exceeded estimate caseload declines and provided fiscal savings beyond that targeted by CMS. So, the Congress should act to sustain enforcement at 60 percent.

As regards to long-term care acute hospitals, CMS has advanced punishing policies that will likely result in payments below cost and that establish unprecedented quotas on referral sources. Instead, CMS should develop facility and patient certification criteria, as MedPAC recommends, to ensure that only the most medically complex patients are treated in these hospitals.

Finally, Mr. Chairman, we support the Subcommittee's interest in reauthorizing the Child Health Insurance program and fixing Medicare physician payment. However, with your PAY–GO responsibilities, funding must be found for these reforms. As Rick Foster, the CMS actuary, has pointed out, Medicare Advantage policies currently weaken the hospital trust fund by an initial 2 years. We believe these policies warrant your reexamination.

In this regard, we hope that you find funding that is fair to the Medicare beneficiaries and to those providing the medical care that beneficiaries depend on and are entitled to receive.

Thank you, Mr. Chairman, and the Subcommittee. I'll be happy to answer questions.

[The prepared statement of Mr. Kahn follows:]

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

U.S. HOUSE OF REPRESENTATIVES

"HEARING ON CERTAIN PAYMENTS TO CERTAIN MEDICARE FEE-FOR-SERVICE PROVIDERS"

TESTIMONY OF

THE FEDERATION OF AMERICAN HOSPITALS

MAY 15, 2007

Presented by:

Charles N. Kahn III
President

On behalf of the Federation of American Hospitals (FAH), I am pleased to offer our views on Medicare fee-for-service payments to hospitals. FAH is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America as well as rehabilitation, long term acute care, psychiatric and cancer hospitals.

Challenges Facing Hospitals

This hearing comes at a crucial time for America's hospitals. Full-service community hospitals are facing growing cost pressures and challenges, none more so than the national crisis of the nearly 46 million uninsured Americans – one in six among us.

No one better understands the crisis of the uninsured than the hospitals they turn to for care, which is why the Federation is proud to have introduced a comprehensive, fair and reasonable plan, entitled "Health Coverage Passport" to cover all Americans. Insuring them is the single most important action Congress can take to increase the health security of all Americans, transform our health care system, make it more patient-centered, increase its efficiency and unlock its value.

The inability of Federal payments to keep pace with rising ho[illegible] costs, howev
- can undermine this dynamic. These are costs over which hospitals have limited control – new and costly pharmaceuticals and medical devices, labor shortages, modernizing facilities, meeting new labor-intensive mandates for quality reporti
- investing in the information systems technology that will drive efficiency and quality gains, maintaining emergency room capacity and securing physician specialists to provide on-call services, and preparing for a possible pandemic or terrorist act, when hospitals will be on the front line to assist the communities th serve.

All of these factors are contributing causes for MedPAC's estimate that the hospital overall Medicare margin will drop to negative 5.4 percent in 2007, the lowest Medicare margin MedPAC has ever reported, and the fifth consecutive y of negative and declining margins, notwithstanding four years of full market bas updates.

That margin decline was a key reason why MedPAC recommended to Congress that hospitals receive a full market basket update in FY08, a recommendation w

fully support. We understand the need for Congress to maintain fiscal discipline as demonstrated by the imposition of "pay-go" this year, and recognize that difficult decisions will need to be made in order to fund national priorities. However, we encourage Congress to strongly consider MedPAC's payment recommendations as it confronts these difficult funding challenges, especially maintaining physician payments and strengthening SCHIP.

As the Congress moves forward this year on these priorities, it is important that policymakers recognize health care coverage and expansion as a societal problem that demands a societal solution, and that they should have available to them every possible funding source to address this dilemma. The Federation believes that one possible source of funding could be the tobacco tax provision that passed the Senate earlier this year.

IPPS Rule

Meanwhile, CMS recently issued its proposed rule governing Medicare inpatient hospital payments for FY08, within which is a proposal, under the guise of DRG payment reforms, to cut hospital payments some $25 billion over the next 5 years. This loss of funding results from an across-the-board 2.4 percent cut in FY08 and another 2.4 percent cut in FY09, as well as cuts to capital payments that would total some $1 billion.

The $24 billion cut is tied to CMS's proposal to restructure the diagnostic related groups (DRGs) in an effort to reflect the relative severity of the patient's medical condition. The Federation is not opposed to thoughtful refinements of the classification system that are used to assign patients into payment categories. However, we are extremely concerned that CMS is acting too hastily in moving forward with this system and has not completed its analysis or provided sufficient justification to impose, in advance of this system, $24 billion in hospital cuts. These cuts, euphemistically referred to as "behavioral offsets," are imposed with scant data to support CMS's assumptions regarding anticipated coding practice. This raises the question as to whether this serious payment cut has more to do with the federal deficit reality than it does with anticipated hospital coding practice under this new, untested system.

For example, CMS cites, as support for the cuts, examples of increases in case-mix index attributable to changes in documentation and coding practice that do not reflect changes in "real" case-mix in three prior instances — when a prospective payment system was introduced for inpatient rehabilitation hospitals and

2002; when the state of Maryland converted to a severity-adjustment system that is substantially different from the one CMS proposes and calls MS-DRGs; and when the original DRG system was implemented for short-stay inpatient hospitals back in 1983.

Each of these experiences presents a flawed precedent for cutting hospitals 4.8 percent and ignores the fact that hospitals have accumulated some 25 years of coding experience and expertise under a classification system that forms the foundation for the new system. The introduction of prospective payment systems as a substitute for cost-based payments, where coding has little payment consequence, presents a fundamentally different situation than what CMS is proposing – in effect, a refinement of an existing PPS. In addition, CMS's proposed refinements, while sharing some similarities to the patient severity adjustment system Maryland has adopted, follow a different coding path, which raises many questions. A proposal to cut $25 billion [illegible] analysis than CMS has shared. Under the system CMS has proposed, there is little opportunity for hospitals to change coding practices, and it is a fallacy to assume that hospitals stand to reap a financial windfall from the movement to MS-DRGs that warrants a prospective 4.8 percent payment cut.

Lacking clear and convincing evidence that MS-DRGs will lead to the case mix changes CMS suggests "might" occur, the more prudent course would be to wait until the system is in place and an empirical analysis can be conducted using actua claims. Appropriate payment adjustments then can be made on the basis of experience rather than conjecture.

The cuts to capital payments are particularly puzzling. For one thing, they are based on an analysis by CMS that purports to show that hospitals are experiencing substantial positive margins under the capital payment framework. The analysis, which averages hospital inpatient Medicare capital margins for the period 1996-2004, is deficient in several respects. The most obvious, of course, is that what hospitals experienced in 1996 is irrelevant to the operating environment today, eleven years later. And as noted earlier, MedPAC estimates an overall hospital Medicare margin in 2007 of negative 5.4 percent. Whether or not hospitals experience a narrow positive margin for their capital payments is of small consequence to the hospital losing money, on average, every time it treats a Medicare beneficiary. Moreover, this should not be discussed in isolation from the overall payment effect in an effort to put the best face on what is a significant capital cut.

Indeed, CMS's analysis concludes in 2004, the year when the margin dropped to its lowest point, 5.1 percent, in the time period CMS selected -- 34 percent below the capital margin in 2003 and 41 percent below the capital margin in 2002. Extending that trend line implies that capital margins today are negative, which should not surprise because it is the very same overall Medicare margin trajectory that MedPAC has documented – a sharp and steady decline since 2002 – from positive 2.4 percent to an estimated negative 5.4 percent in 2007.

These capital cuts also are troubling and counterintuitive because they will seriously impair the ability of hospitals to make the very investments the Administration repeatedly has called for in health information technology, including electronic health records, and to carry out the President's Executive Order. With the many advances in technology, hospitals are constantly looking at ways to evolve toward that ideal hospital of tomorrow, yet these capital cuts send a conflicting message about the degree to which the Medicare program is willing to help bring about these important advancements for its beneficiaries.

Common sense dictates that a hospital must maintain a healthy positive margin, both operating and capital, in order to sustain the level of investment necessary to run a high quality, efficient facility. Instead, the Administration seems to view a modest positive capital margin – 5.1 percent in 2004 (and likely lower today) -- as excessive.

I would also like to applaud Representatives John Lewis and Jerry Weller (and Senators Salazar and Roberts) for their concern about this Rule and their leadership on a letter they are crafting to CMS. The Federation encourages all Members of Congress to sign onto this letter and express opposition to this rule.

Self-Referral to Physician-Owned Specialty Hospitals

The irony of the Administration's proposed cuts is that they flow from payment reforms that were recommended as an answer to the problems posed by physician-owned limited service facilities, otherwise known as "specialty hospitals." MedPAC and others repeatedly have found that limited service facilities engage in patient selection, in effect taking healthy and wealthy patients. These and other findings led MedPAC to recommend that CMS reform the DRG payment system and minimize what it maintained were inaccuracies and distortions in DRG payments that incentivized physician owners to select certain patients. CMS

agreed and began the process of implementing MedPAC's recommendations last year by phasing in cost-based DRGs.

The evidence is inconclusive as to whether these DRG payment refinements lead to more accurate payments or are otherwise an improvement over the DRG system that has functioned reasonably well for over 20 years.

What we can conclude, however, is that these refinements accomplish absolutely nothing with respect to the underlying conflict of interest that drives physician-owners of specialty hospitals. Consequently, the CMS payment changes will have virtually no effect on the proliferation of specialty hospitals, the development of which will always be influenced primarily by self-referral policies and not payment policies.

Payment changes do not eliminate the incentive to increase utilization, especially in outpatient services, to avoid Medicaid and uninsured patients, to divert to their own facilities' well-insured and healthy private pay patients, to avoid emergency room and on-call obligations, or even to continue to engage in careful selection of Medicare patients. For as MedPAC noted, "[o]pportunites for selection never fully disappear," in part because "physicians always know more than CMS about individual patients' expected costs."

And payment changes will have no deterrent effect on the conduct of specialty hospitals that resulted in the multiple tragic and regrettable patient safety problems resulting in patient deaths which have occurred in recent years. We appreciate the steps that CMS is taking to address concerns arising from these situations. While the lack of specialists available to community hospitals for on-call services continues to be a serious problem needing to be remedied, we find it very telling that the limited service facilities, which have exacerbated the on-call availability problem for our members, are apparently themselves often not in position to provide patients with physician care during off peak times to address potential patient emergencies. The limitations associated with this limited service model show that in many instances, these facilities operate as a hospital in name only and do not provide the level of the care in the traditional sense of the term and as Medicare beneficiaries would expect.

Because the Administration has failed to exercise its clear administrative authority to interpret the Stark law the way in which Congress originally intended, we strongly urge the Congress this year to permanently ban self-referral to these facilities.

Medicare Rural DSH

Hospitals in rural America continue to experience unique fiscal challenges that must be addressed, especially when they result from payment inequities embedded in law or regulation. One example of this concerns Medicare disproportionate share hospital (DSH) payments. Currently, hospitals receive Medicare add-on payments to help cover the costs of serving a high proportion of uninsured patients. While large urban facilities (greater than 100 beds) receive DSH payments that more closely correlate with their indigent caseload, rural and small urban facility (less than 100 beds) DSH payments are subject to an arbitrary cap of twelve percent. The Federation supports legislation – most recently included in H.R. 6030 in the 109th Congress – that would remove this cap, bringing rural DSH payments in line with other hospitals.

Quality Measurement, Reporting and Value-based Purchasing

The Federation has been a proponent of quality and performance measurement and reporting for many years, and is a charter member in the Hospital Quality Alliance (HQA) –a multi-stakeholder organization including both the private and public sector which reviews and recommends quality and performance metrics for use by CMS and others. The HQA has proven to be a workable model of the public and private sector collaboration that can contribute significantly to improving the quality of patient care in the hospital and better value for the health care dollar.

The HQA is only one piece of an emerging national quality and performance measurement and reporting infrastructure which has been built over the last decade since the landmark Institute of Medicine reports that called for initiatives to improve both the quality and safety of health care in the United States. This testimony will first examine the role of the HQA and recommend needed policy in the area affecting hospitals, and then will discuss the larger policy critical to making the quality and performance infrastructure achieve its important missions.

Federation hospitals helped initiate and committed to participate in the voluntary quality reporting program that HQA spearheaded and that predated the Medicare Modernization Act (MMA) which eventually required hospitals to report 10 measures in order to receive a full hospital update. Following MMA, the Deficit Reduction Act in 2005 made permanent the requirement to report in order to receive the full market basket update and increased the market basket penalty for non-reporting hospitals from 0.4 percent to 2 percent. Hospitals now must report

on 21 HQA recommended quality measures across three disease conditions (heart failure, myocardial infarction and pneumonia). Thirty-day mortality measures and measures of patient satisfaction (the HCAHPS) currently are being collected and will be publicly reported by June 21 of this year.

Further, CMS's FY08 hospital inpatient proposed rule would add new reporting measures which the Federation supports. In addition, the proposed rule seeks comment on additional measures for 2009 and beyond. The Federation will provide detailed comments and intends to recommend that CMS move forward with collection of data on hospital infection measures. Additionally, Congressional action on physician payment taken at the end of the last Congress also calls for new measures and reporting for outpatient hospital care, so the agenda for hospital reporting is anticipated to expand significantly.

Beyond reporting, CMS now is moving forward on developing its DRA-mandated implementation plan for hospital pay-for-performance program, which HHS is calling "Value-Based Purchasing." Congress will receive CMS's report this summer, and we look forward to working with the Health Subcommittee and others with appropriate jurisdiction as this potentially profound payment change is considered by the Congress.

It is important to note that the data from the current pay-for-reporting program demonstrates, quite clearly, that reporting alone can have a significant effect on hospital performance. Across-the-board improvement can be seen for the quali measures for which reporting are required since the program's inception. Ther every reason to conclude that quality improvement will continue to improve un the current pay-for-reporting program and that as that program expands its performance measurement, it will touch even more areas of patient care.

But while there is an empirical basis for selecting the performance measures an linking reporting and payment, linking payment to quality performance is a relatively nascent concept with little real world experience. The CMS Premier pay-for-performance demonstration has shown positive results as have certain private payer quality performance for payment programs. However, the jury is clearly still out as to whether or not these experiences can be generalized or whether or not their applications have the potential for short term gains but wo result in longer distortions in payment policy.

At this early stage, the Federation urges Congress, should it choose to move forward with a pay-for-performance or value-based purchasing plan, to exercis

extreme caution and to move only incrementally. For example, we suggest keeping incentive bonuses very limited relative to payment and including carefully selected performance measures that can span all hospitals.

While considerably more research and analysis needs to be done, the Fede[illegible] encouraged that CMS's draft VBP plan appears to be moving in the right di on several key issues; most notably; structuring incentive payments to rewa the hospitals achieving predetermined goals as well as those hospitals that demonstrate improvement.

For either the current pay-for-reporting system or a new VBP system to suc the current hospital national quality infrastructure that CMS uses must be strengthened significantly. Pressure continues to build from consumers, the business community, third party payers both governmental and private as w hospitals to add more performance metrics to reporting. Unfortunately, the system lacks the capability and capacity for handling the size and scope of t measures that HQA can recommend. Additional resources are needed both measurement reporting process and display of the results of data submissio

The quality reporting system includes hospitals reporting specif[illegible]data c endorsed by the National Quality Forum (NQF) and recommended by t The data, for the most part, is reported through vendors approved by Th Commission to a data storehouse managed by CMS. CMS has delegate storehouse and its processing function to the Quality Improvement Org (QIO) in Iowa. At the warehouse, the data is validated, and prepared fo on HHS's Hospital Compare Web site.

In the VBP Options paper, CMS recognized that both the storehouse an Compare need additional resources. The Federation strongly endorses t development of a fully funded data storehouse that is chosen by CMS t bidding process.

Further, it is critically important that the data repository accept perform measures across all hospital patients regardless of whether or not they a by Medicare. The current scheme includes data from all adult patients, to incorporate measures relating to the care of children. We believe tha the authority already to fund broad-based reporting, but Congressional may be needed to instruct CMS to use its resources for the inclusion of pediatric as well as adult patients.

The data storehouse should be capable of accepting and processing the full agenda of quality and performance measures that the HQA may recommend and to implement the processing in a timely manner. This data infrastructure and its validation methodology should be transparent, and the data should be generally accessible through the Hospital Compare Web site for seamless use by consumers, private as well as public third party payers, employers, researchers, and physicians and hospitals.

The Federation suggests that in order to further develop the storehouse, CMS should use a competitive bidding process to ensure that the organization is most qualified and that it has no conflicted business interests. It is essential that the enhanced data storehouse be operational in the near future so that the HQA program can meet the mandates of existing legislation for reporting as well as anticipated needs for improving the reporting programs both for governmental and private payers and employers. It appears likely the current storehouse, at existing funding levels, will be incapable of managing even the modest expansion in measures anticipated in the next several years.

In addition, the Federation believes the Hospital Compare Website should be enhanced. Hospital Compare, the publicly-accessible web site that displays hospital-by-hospital performance on the reporting measures is an immensely powerful tool that is driving improvement in hospital performance. It can be a useful portal for helping consumers gain access to meaningful, transparent quality and performance information about the hospitals where they or their family members may seek care.

However, the current web site is frankly not easy to navigate. A new enhanced web site would need to be made more consumer friendly, and it should provide for easy comparison of hospitals across all types of patients. The site must be robust and highly useable for consumers, physicians, providers, employers, third-party payers, and researchers. We commend CMS for recognizing this need and seeking comments on it in its VBP options paper. But the web site needs a major upgrade now, regardless of the fate of the VBP program.

We believe that the current reporting program that HQA has developed and promotes is improving quality in patient care. It has been developed through the contributions of many parties both in the public and private sectors. The HQA's effort results from a blending of public and private commitment, expertise and funding, but it only covers the hospital side of care. The Federation recognizes that patient care proceeds over a continuum that includes various settings, activiti

and practitioners and facilities. Optimal performance and quality measurement must take this into account. So, the further development of the entire quality and performance measurement endeavor needs to be addressed by the Congress.

From the Federation's view, a next step would be Congressional attention to the overall establishment of an overarching quality and performance measurement process. What is needed is a national policy on the priority setting for the development and reporting of quality, safety and performance measurement. Next all the stakeholders have to agree on one endorser of measures, which should be simple, given that the NQF already serves this function, and then there has to be the establishment of responsibility for ongoing monitoring of measures and assurance that measures are harmonious. And, finally, as electronic medical records come on line, the standard setting bodies for health information technology need to be advised on how best to incorporate the requirements of the measure reporting process.

The NQF could serve all these functions with sufficient Congressional direction and funding. The NQF is a multi-stakeholder organization in which 350 organizations representing consumers, purchasers, health care professionals, provider organizations, health systems, health insurers, suppliers, state governments, and federal agencies all participate. The key is for Congress to designate NQF as the National Coordinating and Standard-Setting Center for Performance Measures. With this designation and proper support the NQF could serve as the entity that sets the priorities and agenda for measurement. The NQF could focus physician and provider attention, systematically raise the bar of performance expectations, and assure the efficient and effective deployment of scarce measure development resources.

The NQF could give direction to HQA and its sister organization, the AQA, which serves the same functions for the physician community, as well as others developing and implementing reporting programs.

This designation would also reinforce the current role of NQF of measurement evaluation and endorsement. These functions are critical to the quality improvement activities of providers, informed decision-making by consumers, and accountability and pay-for-performance programs. To meet these broad needs, NQF has to have the resources to consider priority measures without concern for having to find the funds for each evaluation.

Once measures are approved, the measures need to be managed over time. The measure owners who develop the measure themselves have responsibility for keeping the measures relevant both in terms of the science and their applicability to care. But, there should be an overarching manager that assures measure upkeep, and NQF can assume that role for its endorsed measures.

At the same time, NQF is well positioned to facilitate greater communication between the health information technology standard setting bodies, performance measurement community and Electronic Medical Records vendors to encourage the three to move in a direction that will make reporting more automated in an environment with greater availability of electronic medical records. This will help promote measure developers following common conventions and carefully specified measure data elements. Subsequently, NQF could bring closer alignment between performance measures and clinical decision-support.

Finally, with proper agenda setting for measurement development, more funds are needed to finance the development of measures. These funds are not going to be available from any sources other than the federal government, and the HHS Agency for Health Care Research and Quality (AHRQ) is well situated to administer this funding. It should be noted though that AHRQ already provides some support for measure development and funding is needed beyond current levels to meet the needs of clinical practice.

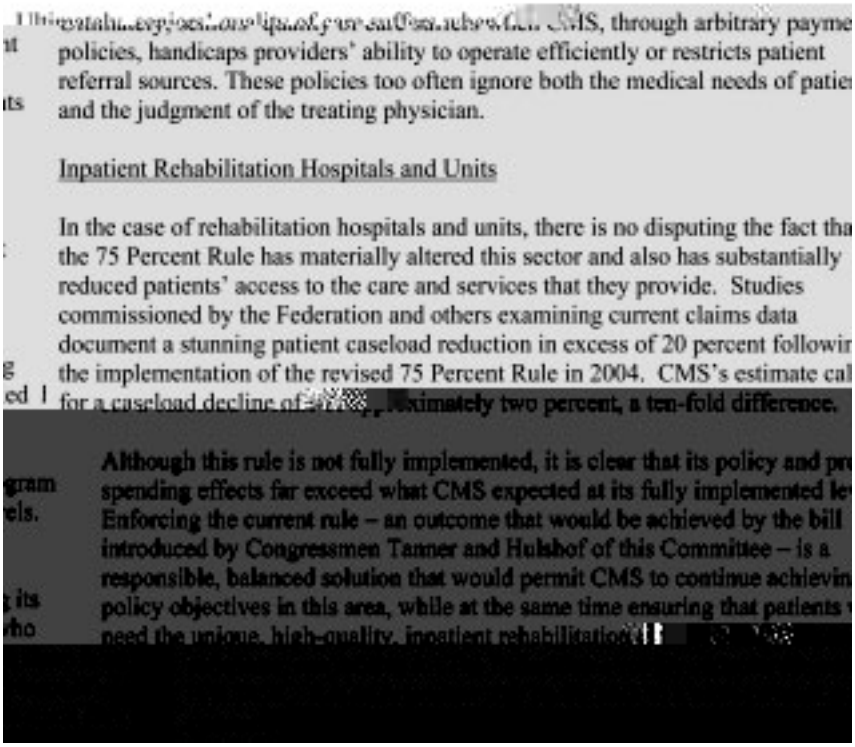
The Federation urges the Committee to consider legislation that would:

- provide competitive bidding for the establishment of and the necessary funding for a national hospital data storehouse for quality measure submission and processing and that the storehouse be funded to collect data across all types of patients for those measures designated by HQA recommendations;
- provide the necessary funding and direction for upgrading the Hospital Compare Web site
- recognize the role of NQF as the national priority and goal-setting organization for quality and performance measurement
- recognize the role of the NQF as the sole evaluator and endorser of measures for the purpose of public reporting programs
- recognize HQA's role as the sole stakeholder group that advises CMS on measure reporting for hospitals
- recognize the role of NQF as the sole organization to oversee the harmonization and maintenance of endorsed measures

- recognize NQF's role in providing guidance to standard setters, measure developers, and electronic medical record vendors regarding measurement and reporting
- provide sufficient funding both for NQF to carry out these functions as well as to the fund additional measure development through the AHRQ

Post-Acute

Other hospital sectors in the post-acute care continuum also are confronting increasingly difficult payment policies as a result of excessive and in some cases reckless regulation that fails to fully recognize the unique clinical benefits of inpatient rehabilitation hospitals and units, as well as long-term acute care hospitals.



CMS, through arbitrary payme
policies, handicaps providers' ability to operate efficiently or restricts patient
referral sources. These policies too often ignore both the medical needs of patie
and the judgment of the treating physician.

Inpatient Rehabilitation Hospitals and Units

In the case of rehabilitation hospitals and units, there is no disputing the fact tha
the 75 Percent Rule has materially altered this sector and also has substantially
reduced patients' access to the care and services that they provide. Studies
commissioned by the Federation and others examining current claims data
document a stunning patient caseload reduction in excess of 20 percent followir
the implementation of the revised 75 Percent Rule in 2004. CMS's estimate cal
for a caseload decline of approximately two percent, a ten-fold difference.

Although this rule is not fully implemented, it is clear that its policy and pr
spending effects far exceed what CMS expected at its fully implemented le
Enforcing the current rule – an outcome that would be achieved by the bill
introduced by Congressmen Tanner and Hulshof of this Committee – is a
responsible, balanced solution that would permit CMS to continue achievin
policy objectives in this area, while at the same time ensuring that patients
need the unique, high-quality, inpatient rehabilitation

We also are concerned about the high rate of denied claims by fiscal intermediaries asserting lack of medical necessity, which inpatient rehabilitation hospitals and units have experienced over the past 12 to 18 months, and continue to experience. Most of these denials ultimately are reversed by administrative law judges, but only after lengthy and costly litigation proceedings, depleting resources that could otherwise be devoted to patient care. We believe many of these denials are inconsistent with applicable medical necessity criteria for the Medicare program's inpatient rehabilitation benefit. H.R.1459 would help alleviate this problem by codifying long-standing criteria used to determine medical necessity of inpatient rehabilitation.

Long Term Acute Care Hospitals (LTACHs)

LTACHs may be the most misunderstood and unfairly maligned hospital sector. CMS recently finalized a LTACH payment rule that implements far-reaching policy changes for LTACHs that affects both the acute and post-acute sectors. These latest changes to the LTACH payment system come on the heels of three years of payment cuts for LTACHs, the cumulative effect of which is to reduce payments well below the cost of caring for Medicare's most medically complex patients.

Specifically, even before the Final Rule, MedPAC estimated that LTACH Medicare margins are between zero and 1.9%. CMS projects that in the first year alone the Final Rule will reduce LTACH payments by an additional 3.5%, well below costs, and that in future years payments will drop even further. In addition, CMS payment policy has brought LTACH growth to a virtual standstill.

What is particularly troubling is that the Final rule not only arbitrarily reduces LTACH payments below the cost of care, it imposes an arbitrary cap (25 percent) on the percentage of patients that freestanding LTACHs can admit from any primary referral source without suffering a payment penalty. FAH is very concerned about the dangerous precedent of setting limits on where physicians can send patients for treatment, especially when these limits are not based on any clinical considerations but instead are based on arbitrary caps with no relationship whatsoever to patient needs.

In addition, CMS imposes a severe payment penalty for cases that CMS characterizes as "very short stay." These payment penalties apply to a large number of so-called "short stay" patients whose length of stay in LTACHs is actually close to or in excess of 25 days, the current criteria needed to qualify as a

LTACH. Again, this payment policy ignores the clinical characteristics and costs of caring for these patients and is predicated, in large part, on a misguided and unsupported notion that short-stay acute care hospitals are discharging patients "early" to LTCHs in order to maximize DRG payments or otherwise avoid losses under the prospective payment policy. The data clearly refute this assertion.

The time is long past due for CMS to advance the June 2004 recommendations from MedPAC to modernize and strengthen the certification criteria for LTACHs to ensure that LTACH payments are being made only to those providers that are administering medically complex care to severely ill patients. As MedPAC recently reiterated in its comments about the LTACH proposed rule, CMS should pursue facility and patient criteria rather than "approaches other than criteria… such as the 25 percent rule…[that] are more arbitrary and increase the risk for unintended consequences."

This clearly is the preferred policy route to define the appropriate role of LTACHs in the post-acute continuum, and one which FAH strongly supports. Along these lines many members of both the Senate and House of Representatives, led in the House by Representatives English and Pomeroy, have expressed their opposition t CMS's LTACH rule and have indicated their strong preference that CMS implement revised certification criteria for LTACHs.

Conclusion

America's hospitals are at a crossroads. We need the support of Congress to continue our vital mission of serving the health care needs of every American in every community across the country, 24 hours a day, seven days a week, under every and any circumstance, and with the highest quality care possible. Federal payment policies are one of the most important factors in determining our ability t meet that mission. And yet, as outlined above, we are concerned that some of those key policies will hinder rather than help us achieve this shared goal.

Overall Medicare hospital margins are negative and falling. However, CMS proposes a payment rule that only will exacerbate this deteriorating Medicare hospital fiscal condition at the same time that physician-owned limited service facilities, built on a foundation of self-referral, continue to flourish. Our hospitals will embrace change, including a restructured DRG system, but we have to be convinced that the change that is being proposed is thoughtful, based on empirical evidence, and in the best interests of the beneficiaries we exist to serve. Our

analytic work continues, but at this point we are not yet convinced that this proposal meets that test. Certainly, there is no basis for a 4.8 percent payment cut.

The same is true of the movement towards pay-for-performance. CMS has put forward a draft plan that has many thoughtful elements. However, there still are too many unanswered questions, first and foremost being whether such a system truly is necessary, what are the potential unintended consequences, and will it improve quality much more than the improvements in quality we already have witnessed through the quality reporting program that still is in its infancy.

Finally, I believe everyone here recognizes the need to create a more rational post-acute care payment and delivery system that more clearly defines the appropriate role of the various providers in the post-acute continuum. But this need does not justify abrupt and unreasonable regulations that substitute blunt payment policies for thoughtful, data-driven analysis, and which may have adverse consequences for seniors. For example, nursing homes have an important place in this continuum, but they are not structured to provide the high-quality, intensive rehabilitative and medical, rather than custodial care, that inpatient rehabilitation hospitals routinely provide. In the same vein, long term acute care hospitals may cost more, but the intensity of the hospital care they provide for the most medically complex seniors is unmatched. In short, they deliver value, and are a critical asset as we strive to deliver the quality of care that seniors deserve.

Mr. Chairman, on behalf of the Federation's hospitals, I want to thank you for holding this important hearing, and for giving us the opportunity to testify. I would be pleased to answer any questions you or the other members of the Committee may have.

Chairman STARK. Thank you, Chip.

Mr. Umbdenstock, would you like to inform and enlighten us in any way you'd care?

STATEMENT OF RICHARD J. UMBDENSTOCK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN HOSPITAL ASSOCIATION

Mr. UMBDENSTOCK. Thank you, Mr. Chairman. It's my pleasure to be here today on behalf of our 5,000, nearly 5,000 member hospitals.

Mr. Chairman and Members of the Committee, the men and women of hospitals do great things in the face of very tough challenges. Demand is soaring, and the resources needed must keep up. My task today is to briefly explain how Congress can help hospitals face those challenges.

First, we appreciate that Congress has rejected the more than $100 billion in cuts to Medicare and Medicaid that the Administration had proposed. Neither chamber's budget resolution contains cuts to these programs, and 223 House Members and 43 senators signed letters specifically opposing such cuts. We urge Congress to continue to hold the line on cuts.

Mr. Chairman, we support your efforts to do away with the 45 percent trigger, an arbitrary and misguided approach to dealing with the challenges facing Medicare.

We urge you to follow the recommendations of MedPAC to grant a full update for inpatient and outpatient services. This is critical to ensuring that Medicare reimbursement keeps pace with inflation and to reversing the dramatic decline in hospitals' Medicare margins. MedPAC projects Medicare margins to fall from negative 3.3 percent in 2005 to negative 5.4 percent in 2007, a ten-year low. With 65 percent of hospitals being paid less than the cost of services provided to Medicare patients, a full update is not just warranted, but necessary.

However, what is unwarranted and unnecessary is the CMS proposal to cut $25 billion in payments for the services that beneficiaries need. First, they cut $24 billion by asserting that hospitals might change coding practices as a result of the new severity-adjusted DRG system. The new DRGs are simply a refinement of a classification system that hospitals have been using for 23 years. As a result, there is unlikely to be any change in coding practices.

Second, CMS proposes cutting capital payments by nearly $1 billion. Urban hospitals in particular would be deeply affected. CMS went well beyond its charge by recommending these two significant changes, and their action clearly exceeds Congressional intent. Two Members of the Committee, Representatives John Lewis and Jerry Weller, are circulating a letter among their colleagues calling on CMS to eliminate these provisions. We appreciate their efforts, and we urge Congress to do whatever is needed to block these provisions.

Regarding inpatient rehabilitation facilities, the 75 percent rule is making it difficult for patients to get the care they need. A study recently found that nearly 88,000 patients were unable to receive care in rehabilitation hospitals during the first 2 years of the 75 percent rule phase-in, an assessment that far exceeds CMS' original estimate of 7,000 patients. We therefore oppose moving to the 65 percent threshold in July.

We are equally concerned that many Medicare fiscal intermediaries have further restricted the number of patients who can be treated by these hospitals by issuing local coverage determinations based on unreasonable definitions of medical necessity. The AHA supports ensuring that all fiscal intermediaries use the national guidelines currently in place for medical necessity. Passage of H.R. 1459 would accomplish this goal.

Regarding limited service hospitals, we strongly urge Congress to enact a permanent ban on physician self-referrals to limited service hospitals, with limited exceptions for existing facilities that meet strict investment and disclosure rules. When decisions are made with the doctor-owner's bottom line in mind, it's not in the patient's best interest. So, self-referral should be banned.

Rural hospitals provide essential health care services that 9 million Medicare beneficiaries need. Yet Medicare margins are the lowest for rural hospitals. The AHA supports H.R. 1177, which would extend permanently the outpatient PPS hold harmless provision for sole community hospitals, along with a number of other rural initiatives outlined in our written statement.

The AHA is strongly opposed to a provision in the Administration's FY08 budget that recommends a nearly $5 billion reduction over the next 5 years in payments to hospitals for graduate medical education. The Medicare Advantage plans, however, would continue to receive fundings for GME costs. We ask that the Subcommittee protect the payments to teaching hospitals, and we suggest that a source of legitimate savings in the Medicare program would be GME payments to Medicare Advantage plans that are not reaching the teach organizations.

In addition, some Medicare Advantage plans are not reimbursing critical access hospitals at 101 percent of their cost as traditional Medicare does. H.R. 2159 would correct this inequity.

Mr. Chairman, hospitals face significant challenges as they strive to provide the best care possible to Medicare patients. You have our pledge to help the Medicare Program accomplish its important goal.

Thank you.

[The prepared statement of Mr. Umbdenstock follows:]

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Testimony
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives

" Payments to Certain Medicare Fee-for-Service Providers "
May 15, 2007

Good afternoon, Mr. Chairman. I am Rich Umbdenstock, President and CEO of the American Hospital Association (AHA). On behalf of the AHA's nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, I appreciate the opportunity to testify before you today about payments to hospitals.

HOSPITALS – BUILDING BETTER LIVES AND COMMUNITIES

Hospitals are cornerstones of their communities. The doors of the local hospital are open 24 hours a day, seven days a week, every week of the year. The women and men of these hospitals take care of all who walk through the hospital doors, regardless of their ability to pay for that care. Our doctors, nurses and other professionals take care of people at all stages of life, from birth until old age. Hospitals stand ready to respond in the wake of a catastrophic event, whether caused by man, like a bioterrorism attack, or nature, like floods and tornadoes. And hospitals work not just to mend bodies, but also to make the entire community healthier. Their work extends far beyond the four walls of a brick building and includes bringing free clinics, job training, smoking cessation classes, back-to-school immunizations, literacy programs and so many other resources, often with little fanfare, directly to the people of the community.

At the same time, the local hospital is more than a place where people go to get well. Hospitals are employers, providing good wages and stimulating other areas of business throughout the community. Hospitals employ nearly five million people, rank second as

a source of private sector jobs, directly or indirectly support one of every nine jobs in the U.S., remain a stable source of employment, even during times of economic stress; and support other businesses when they purchase the goods and services needed to provide care. The well-being of a local hospital can cause ripple effects on the economic health of a community.

And that well-being is at risk. To meet the unique needs of their communities, hospitals face unique challenges. More than 115 million people are treated in our emergency departments each year; more than 35 million patients are admitted each year. Hospitals are the primary place of care for many of the nation's 45 million uninsured people. In 2005, hospitals provided $29 billion of uncompensated care. We must be prepared to respond to any threat to the community, and we must invest in newer cutting edge technologies and facilities in order to keep up with soaring demand. Yet more than half of our patients are covered by government programs – Medicare and Medicaid – that pay us far less than the cost of caring for those patients.

PROPOSED MEDICARE AND MEDICAID CUTS

Despite these demands and challenges, the Administration's fiscal year (FY) 2008 budget proposal seeks more than $100 billion in overall cuts to Medicare and Medicaid over the next five years, a significant portion from hospital services. Cuts of this magnitude would not only affect the hospital services that Medicare and Medicaid beneficiaries rely on, they would affect services for all Americans in all communities.

Fortunately, Congress disagrees with these proposed cuts. A bipartisan group of 223 House lawmakers, led by Reps. Richard Neal (D-MA) and Phil English (R-PA), and 43 senators, led by Sens. Blanche Lincoln (D-AR) and Pat Roberts (R-KS), signed letters to budget leaders calling for Congress to protect hospital services under Medicare. In March, both the Senate and House

[redacted]

MEDPAC'S RECOMMENDATIONS

The Medicare Payment Advisory Commission (MedPAC) recently agreed that the challenges facing hospitals are serious. MedPAC recommended that Congress grant a full market basket update for hospital inpatient and outpatient prospective payment systems (PPS) in Fiscal Year 2008. We encourage Congress to follow MedPAC's recommendation.

We appreciate MedPAC's recognition of the need to ensure that Medicare reimbursement keeps pace with inflation and the changing needs of our health care system. Americans depend on hospitals to be there, ready to serve, 24 hours a day, 365 days a year. Reversing the dramatic decline in hospitals' Medicare margins is essential to ensuring hospitals' ability to fulfill this expectation.

Here are just some of the pressures and challenges that bolster the case for a full update for hospitals:

- MedPAC projects overall Medicare margins to continue to fall, from *negative* 3.3 percent in 2005 to *negative* 5.4 percent in 2007 – a 10-year low.
- Sixty-five percent of hospitals are paid less than the cost of services provided to Medicare patients, a shortfall that exceeds $15 billion.
- We continue to face a severe shortage of workers to meet increased demands for care. For example, there is expected to be a shortage of more than 1 million nurses by 2020. Training and retaining skilled workers of all types requires considerable investment.
- Spending on health IT systems is high and growing. The median capital spending per bed for system implementation was $5,556 in 2006. The median operating costs to cover ongoing expenses were $12,060 per bed, a 4.5 percent increase over 2005.

Indirect Medical Education (IME). In January, the commission recommended that Congress reduce the indirect medical education adju

THE CMS INPATIENT RULE

CMS' proposed Medicare inpatient rule for FY 2008 includes dramatic cuts – $25 billion over the next five years – to services that are needed by America's seniors and disabled. It does this in large part by imposing a 2.4 percent, across-the-board cut, in each of the next two years, in anticipation of the coding changes it says hospitals *might* make under a new severity DRG system and by cutting important capital payments.

The "Behavioral Offset." The proposed rule calls for refinement of the DRGs, which will result in changes to Medicare payments. The AHA continues to analyze the new DRGs and their ability to improve the accuracy of Medicare payments. But the 2.4 percent "behavioral offset" is a key misstep. The $24 billion cut over five years to capital and operating payments is based on CMS' apparent belief that, with implementation of its Medicare Severity Diagnosis-Related Groups (MS-DRGs), the changes hospitals will make in coding practices will result in higher payments. CMS maintains that under a "new" system of DRGs hospitals will change coding behavior. Yet, even during the initial years of the inpatient PPS, when hospitals moved from a cost-based system to a prospective DRG system, we did not see coding changes of the magnitude that CMS anticipates in attempting to justify this dramatic cut. MS-DRGs are based on the existing DRG system and are simply a refinement of a classification system that hospitals have been using for 23 years. Hospital personnel already are coding experts with DRGs and are using coding forms and practices that have been in place for a long time.

CMS also cites as rationale for the cut the transition of hospitals in Maryland to a completely new coding system called All Patient Refined DRGs. But this rationale also is flawed. Maryland's hospitals are paid under a state rate-setting system. Historically, coding in the Maryland hospital payment system was not a significant factor in determining hospital payments. The classification system recently adopted by Maryland is much more complicated than what CMS has proposed and, in fact, completely changed the coding incentives for Maryland's hospitals. Applying the Maryland experience to the rest of the nation's hospitals is an inappropriate apples-to-oranges comparison.

There is no precedent in other payment systems for making a prospective adjustment of this magnitude without any evidence of actual and measurable changes in coding. While CMS has made adjustments for coding in the implementation of new payment systems, these changes have been based on actual experience. When the new physician fee schedule was implemented in 1992, CMS imposed a behavioral offset based on predicted increases in the volume of services physicians would provide. It was later learned that the estimated offset cut much more payment than necessary, yet the funding was never returned to physicians who were adversely affected by those cuts.

Capital Cuts. CMS is required by law to pay for a portion of the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for new facilities, renovations, expensive clinical information systems and high-tech equipment like MRIs and CAT scanners. This is done through a separate capital PPS. Since the PPS for inpatient capital costs uses DRGs in its payment formula, the 2.4 percent cut already reduces payments for urban and rural hospitals.

CMS's proposed rule also would eliminate the annual update for capital payments for all hospitals in urban areas and would eliminate additional capital payments made to hospitals in large urban areas. In addition, CMS is considering discontinuing the IME and DSH adjustments to capital payments. Eliminating the update and the loss of the additional large-urban hospital payments would cost those hospitals $880 million over the next five years.

These proposed cuts to capital payments would make it more difficult to purchase the advanced technology, equipment and clinical information systems that consumers have come to expect and could have the effect of slowing clinical innovation. Capital cuts of this magnitude will disrupt the ability of urban hospitals to meet their existing long-term financing obligations. Hospitals have committed to these improvements under the expectation that Medicare's prospective payment system for capital-related costs would remain a stable source of income. Reducing capital payments creates significant financial difficulties for many of our nation's innovative and cutting edge hospitals.

CMS cites as its rationale that financial margins for capital are excessive in hospitals in urban areas. It is important to note, however, that actual overall Medicare margins for these hospitals averaged -3.3 percent in 2005, according to MedPAC. In addition, taken by themselves, capital margins don't reflect the cyclical patterns of capital investment by which hospitals replace facilities, purchase and improve information systems or update clinical technologies. Indeed, the very nature of a PPS is to provide a consistently reliable flow of funding so that hospitals can plan their capital expenditures – in times of high or low capital costs.

We believe CMS went well beyond its charge by recommending both of these arbitrary and unnecessary changes. They will deplete scarce resources, ultimately making hospitals' mission of caring for patients even more challenging. The Federation of American Hospitals, the Association of American Medical Colleges, the National Association of Public Hospitals and Health Systems, Premier, Inc., and VHA Inc., along with the AHA, recently sent a letter to Acting CMS Administrator Leslie Norwalk urging her to eliminate the two provisions from the rule.

Two members of the Ways & Means Committee, Reps. John Lewis (D-GA) and Jerry Weller (R-IL), are circulating a Dear Colleague letter with the same purpose. The letter also will be sent to Acting Administrator Norwalk.

The cuts clearly fly in the face of congressional intent. As stated above, 43 senators and 223 representatives recently signed letters opposing budget cuts to Medicare and Medicaid. Nowhere are the cuts CMS is proposing mandated by the Congress. At a time when Medicare must be strengthened to meet soaring demand for its services, CMS is instead sapping its strength, and the ability of hospitals to meet the needs of patients will be sapped as well. We urge you to insist that CMS remove these unwarranted and unwise cuts from the proposed rule.

INPATIENT REHABILITATION HOSPITALS AND UNITS

Inpatient rehabilitation facilities treat seriously ill and injured patients, but restrictive Medicare policies, such as the 75% Rule and stringent definitions of "medical necessity," are making it more difficult for these patients to get the care they need. The 75% Rule is one of the criteria an inpatient rehabilitation facility must satisfy to be eligible for Medicare reimbursement under the inpatient rehabilitation PPS. When fully phased in, 75 percent of patients discharged must be treated for one of 13 conditions in order to qualify for rehabilitation-specific payments.

Currently, the patient threshold is set at 60 percent, but it is set to rise to 65 percent in July 2007 and 75 percent in July 2008. The Moran Group, a Washington, DC-based health care research and consulting firm, recently found that nearly 88,000 patients were unable to receive care in rehabilitation hospitals and units during the first two years of the 75% Rule phase-in – an assessment that far exceeds CMS' estimate that only 7,000 fewer patients would be treated. CMS' policies have severely reduced, beyond what was intended, access to the medical rehabilitation care that patients need, and the AHA opposes moving to the 65 percent threshold in July.

The AHA is equally concerned that many Medicare fiscal intermediaries (FIs) have further restricted the number of patients who can be treated at inpatient rehabilitation hospitals and units by establishing local coverage determinations (LCDs) based on overly stringent definitions of "medical necessity." As a result, patients who should be eligible for rehabilitation care are being turned away. And, because no uniform standards exist, some FIs are employing far more restrictive standards than others, creating an unfair competitive environment for inpatient rehabilitation hospitals and units that are located in the same community but have to follow the disparate rules of different FIs.

The AHA supports removing overly restrictive LCDs and ensuring that all FIs use the national guidelines currently in place for medical necessity. We urge Congress to pass the *Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007* (H.R. 1459), introduced by Reps. John Tanner (D-TN), Kenny Hulshof (R-MO), Nita Lowey (D-NY), and Frank LoBiondo (R-NJ). The bill would freeze the 75% Rule at the current 60 percent level and address inconsistent and harsh LCDs.

In addition, the 75% Rule, even at a transitional level, has already changed the course of inpatient rehabilitation facility payment by creating significant instability. To avoid further erosion of beneficiary access to quality inpatient rehabilitation care, a full market basket update is warranted.

LONG-TERM CARE HOSPITALS

In FY 2005, CMS implemented the 25% Rule for long-term care hospitals (LTCHs) that were co-located within acute care hospitals. When fully phased in, this policy, currently at 50 percent, would require that only 25 percent of admissions to the LTCH can be patients who were previously admitted to the co-located acute care hospital. For LTCHs exceeding this 25 percent patient threshold, CMS will reimburse the LTCH at the lower

payment rate for general acute care hospitals. CMS' rate year 2008 final rule for LTCHs recommends several troubling changes – most notably CMS' plan to extend the 25% Rule to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. This expansion of the 25% Rule, phased in over three years, would reduce payments to LTCHs by $406 million over the next three years.

The AHA supports efforts to more specifically define patient and facility criteria for LTCHs. However, the 25% Rule misses the mark by arbitrarily limiting the number of patients who can be admitted, rather than focusing on patients' clinical characteristics and their need for long term care. LTCHs provide intense care to patients who require longer lengths of stay than typical patients in a general acute care hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for whom LTCH care is medically appropriate – a view supported by MedPAC.

Last year, CMS released a report by the Research Triangle Institute (RTI) that identified patient and facility criteria that would help distinguish LTCHs from other acute care facilities. However, CMS has not yet used the report to produce specific policy recommendations. Rather than limiting access to LTCH services through payment cuts, we urge CMS to stop the proposed rule and work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.

RURAL HOSPITALS

Rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries. Because of their small size, modest assets and financial reserves, and higher percentage of Medicare patients, these hospitals face enormous pressures as government payments decline. Yet, Medicare margins are the lowest for rural hospitals, with the smallest hospitals having the lowest margins.

Tremendous diversity exists among rural hospitals and different approaches are needed to reach the common goal of providing access to high quality care for Medicare beneficiaries who live in rural areas. National payment policies, specifically prospective payment systems, often fail to recognize the special characteristics and unique circumstances of small rural hospitals. Some rural hospitals are too large to qualify for status as a Critical Access Hospital (CAH) but too small to absorb the financial risk associated with PPS programs. As a result, the AHA supports the following legislation, which was introduced earlier this year:

The Sole Community Hospital Preservation Act (H.R. 1177) – Introduced by Reps. John Tanner (D-TN) and Sam Graves (R-MO), this bill would extend permanently the outpatient PPS payment protection for sole community hospitals – the "hold harmless" – and permit the use of a more current year to allow re-determination of the hospital target amount.

The Physician Pathology Services Continuity Act (H.R. 1105) – This bill, introduced by Reps. John Tanner (D-TN) and Kenny Hulshof (R-MO), would permanently extend current law to allow Medicare to continue to make direct payments to certain independent laboratories for the technical component of pathology services.

The AHA also supports the extension of expiring legislative provisions affecting rural hospitals, including a rural home health 5 percent add-on, cost-based payment for rural laboratory services provided by hospitals with fewer than 50 beds, and ambulance mileage bonuses for transport of rural patients in low-population density areas. We support extension of Section 508, which allows geographic reclassification of certain hospitals.
In addition, we support the expansion of existing cost-based payment to home health and skilled nursing facility settings for CAHs, and to rural hospitals with 25-50 beds for inpatient and outpatient services. We also support allowing flexibility in the relocation of CAHs, allowing CAHs to be used as reference labs to provide services to beneficiaries. We also need to ensure that CAHs are paid at least 101 percent of costs by Medicare Advantage plans. H.R. 2159, introduced by Reps. Ron Kind (D-WI) and Cathy McMorris-Rodgers (R-WA), aims to correct the inequity of how rural hospitals are paid by Medicare Advantage plans.

PHYSICIAN-OWNED, LIMITED SERVICE HOSPITALS

Although a congressional moratorium and subsequent Department of Health and Human Services administrative action from late 2003 to mid-2006 was supposed to hold in check the expansion of physician-owned, limited service hospitals, their growth is on the rise. Many public and private studies conducted during the moratorium found that physician-owned, limited-service hospitals:

- Reduce patient access to specialty and trauma care at community hospitals;
- Damage the financial health of full-service hospitals and lead to cutbacks in services;
- Reduce efficiency of full-service hospitals that must maintain stand-by capacity for emergencies, even as they lose elective cases;
- Increase utilization rates and costs;
- Are not more efficient and do not provide better quality;
- Use physician-owners to steer patients;
- Provide limited or no emergency services; and
- Select the most profitable patients by:
  - Avoiding low-income populations, both uninsured and Medicaid;
  - Offering the most profitable services; and
  - Serving less sick patients within case types.

The proliferation of physician ownership of limited-service hospitals is stimulated by opportunities to earn additional income and gain greater control over their operating environment. However, the effect on health care delivery and costs in communities can be devastating, especially when self-referral is involved.

To help ease the effects of these and other issues surrounding limited-service hospitals, the AHA supports a permanent congressional ban on physician self-referrals to limited-service hospitals, with limited exceptions for existing facilities that meet strict investment and disclosure rules. We urge Congress to act this year.

MEDICARE ADVANTAGE

The Medicare Advantage (MA) program made major changes in the types of private health plan options available to Medicare beneficiaries. In addition to the traditional coordinated care plans, beneficiaries now have access to regional preferred provider organization (PPO) plans, private fee-for-service (PFFS) plans, and Medical Savings Account (MSA) plans. Implementation of Medicare Part D drug coverage has changed the dynamics of the program as well. Changes in MA plan payments have also led to higher payments to plans, and changes regarding where new plans are being offered and where the growth in new enrollment is concentrated.

With MA plans in place for several years, we now have some experience with the changes that have resulted. The AHA has identified four specific areas of concern that are causing difficulties for hospitals, especially rural hospitals, and for the Medicare beneficiaries they serve.

Elimination of IME payments. We are strongly opposed to a provision in the Administration's FY 2008 budget that would eliminate the indirect medical education (IME) payment made to teaching hospitals on behalf of MA enrollees when they receive care in a teaching hospital. This proposal would save approximately $5 billion over the next five years. MA plans, however, would continue to receive funding for costs related to indirect medical education even though they do not pass those payments on to teaching hospitals. It is outrageous to eliminate payments to hospitals that are providing Medicare beneficiaries with future generations of physicians, while at the same time protecting payments to plans that rarely, if ever, pass those payments on to the teaching hospitals that need them, as the plans are not required to do so. We ask that the subcommittee protect these much-needed payments to teaching hospitals. And we suggest that a prime source of legitimate savings in the Medicare program would be removing IME payments from the MA rates, while continuing to make IME payments directly to teaching hospitals when they serve MA enrollees.

Underpayment of Rural and Critical Access Hospitals. Federal law requires that MA plans pay out-of-network providers what they otherwise would have been paid under the traditional Medicare program. For PFFS plans, this requirement applies to "deemed providers" who are presumed to have accepted the plan's terms and conditions for payment without a contract. Traditional Medicare pays CAHs 101 percent of costs. As a matter of convenience for MA plans, CMS allows them to pay CAHs a proxy amount or interim payment rate. But, interim rates are based on the prior year's costs. Unlike traditional Medicare, where there is a year-end settlement based on actual costs, MA plans are not required to reconcile these proxy payments with actual amounts due to CAHs. This is also true for sole community providers, rural health clinics (RHCs), and

others paid on a cost-related basis. Recognizing the inequity of this situation, legislation has been introduced in the House (H.R.2159, by Reps. Ron Kind (D-WI) and Cathy McMorris-Rodgers (R-WA)) that would require all MA plans to pay CAH and rural health center services, at minimum, their interim rate with year-end cost reconciliation, or 103 percent of interim rates without reconciliation. AHA supports these legislative efforts. Given that MA plans are paid substantially more than traditional Medicare costs, rural health care providers should not pay the price for MA plan convenience.

Questionable Marketing Practices. Based on beneficiary complaints and congressional hearings, it is clear that some Medicare beneficiaries are sold MA plans without good information about important issues like how those plans operate, access to providers and copayments. This is especially true with PFFS plans, which have been characterized by some as being no different from the traditional Medicare program with full access to all Medicare-certified providers. While CMS has said it will increase oversight of PFFS plans, the agency's plan to do so misses a key complaint: beneficiaries seeking to enroll in a part D drug benefit plan who are instead enrolled in a PFFS MA plan. These beneficiaries are asking for one thing and getting another. Those who are unaware that they have signed up for an MA plan present their old Medicare cards to providers, and it is not until the provider's claims are rejected that either the beneficiary or the provider is aware of their actual plan coverage. As a result, beneficiaries may be unwittingly subject to a higher copayment for failing to notify the plan before their admission, and higher copayments than the traditional Medicare program. CMS needs to put a stop to misleading or fraudulent marketing practices and ensure that Medicare beneficiaries can return to the traditional Medicare program without any penalty or loss of supplemental coverage.

Confusing Plan Variations and Poor Plan Administration. Differences among MA plans, the sheer number of plans available in some areas, and the fact that MA plans are not required to follow state insurance regulations is causing confusion among providers as well as beneficiaries. PFFS plans present some of the worst administrative problems, especially for rural providers. The "deemed provider" approach is most problematic. If a hospital serves a Medicare PFFS enrollee, the hospital is deemed to accept the PFFS plan's terms and conditions unless it is providing emergency care. PFFS plans enter rural markets and enroll beneficiaries without any notification to the area's health care providers. Providers have no opportunity to review the plan's terms and conditions and must make on-the-spot decisions when new enrollees begin to seek services. In the absence of contracts with these plans, providers have no ability to negotiate terms and conditions. Simplification of administrative requirements and an overhaul – if not elimination – of the "deemed provider" concept must be considered.

In those instances where plans are providing actual care management services, like those provided by Kaiser Permanente, Sentara, and Providence Health System, payments above fee-for-service may be appropriate. However, as stated above, we are hearing from our rural members that private fee-for-service plans, in addition to the problems outlined above, provide little care management but still receive additional payments, and are creating difficulties for rural hospitals. Consequently, we ask that the subcommittee

further investigate the activities of private fee-for-service plans, and make adjustments to their payments if they are found not to provide true care management for beneficiaries, and are not working with hospitals that are so vital to health care in their rural communities.

CONCLUSION

Mr. Chairman, the women and men of our hospitals face significant challenges as they strive to provide the best care possible to their friends and neighbors in communities across our nation. But, while the challenges are complex, their mission is simple: Get people the right care, at the right time, in the right place. You have our pledge to work with you to address these complex challenges in a way that helps us accomplish that goal.

Chairman STARK. Thank you. Mr. Yarwood, would you like to proceed?

Mr. YARWOOD. Sure. Do you want me to just go off message, or do you want me to read this to you?

[Laughter.]

Chairman STARK. Whatever you want to do. I was just wondering if we changed the Stark laws to the Camp laws whether the Administration might be more apt to enforce them.

Mr. CAMP. I wouldn't count on it.

Mr. YARWOOD. Well, the staff behind me is—they have over—under 30 seconds of how long it will take me to go off message. So, I'll try my best.

STATEMENT OF BRUCE YARWOOD, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN HEALTH CARE ASSOCIATION/ NATIONAL CENTER FOR ASSISTED LIVING

Mr. YARWOOD. Most of what I've had to say has been gone over and somewhat repetitive, but let me start. As you know, I am honored to be here and don't do this very often, so, thank you. But I'm on here on behalf of—we have 11,000 member facilities and nearly 2 million employees that work for us, significant impact on what we do.

The nursing home of 30 years ago primarily cared for chronically ill residents with long lengths of stay. Today, nursing homes are developing to meet specific needs of today's aging American. We're seeing developments in services for more clinically complex patients with increased level of short-term rehabilitative care and services, an average length of stay of 25 days.

During this time, I've also seen a positive shift in which quality improvement programs are focused on delivering the highest quality patient care. You can recall 7 years ago, we had more than 2,000 long-term care facilities in bankruptcy, primarily as the result of an altered payment system that we had a hard time adapting to. These bankruptcies really threatened our ability to take care of folks. But progress has been achieved due to the fact that providers, regulators, lawmakers and consumers have established a more productive cooperation culture, which is undoubtedly con-

tributing to the rising care quality and the standards of America's nursing homes.

To continue the positive trends and make necessary investments to prepare for this aging population, the long-term care profession requires continued financial stability. The yo-yo effect hurts us a lot. The link between stable funding and quality has been noted time and time again.

I might just add that recently we had—we rolled out something called My Innerview, and what it showed is that in a survey of nearly 100,000 nursing home patients and their families, the vast majority, more than four out of five, are highly satisfied with the care provided in our nursing homes. Only 3 percent rated the satisfaction level as poor.

As has been said more than once today, at present, there's an excessively fragmented, irrational health services payment structure. When it comes to post-acute, now we have it backward. Our post-acute payment structure is tied to the setting in which patients are placed, not to the patients and the services required.

For certain diagnostic conditions, the inpatient rehab facility and long-term care hospital payments can be much higher than the SNF payments. Some of this is clearly due to the variations in the severity of illness. Yet because there are no common patient assessment tools or outcome measures across all settings, it is not possible to determine whether patients are being treated in the most appropriate setting, and whether resources are being allocated sufficiently and appropriately.

Until a uniform system is finalized and applied, health care professionals must do a better job placing acute, post-acute patients in the most appropriate care settings. We support the use of hospital discharge planning as the starting point to standardize the post-acute assessment tools.

Mr. Chairman, at a time when the Administration and Congress are considering budget cuts in many essential health care programs, our first priority must be to ensure that we spend the existing resources wisely, as you well know. We are severely concerned about the potentiality of the cuts since we have been working real hard to balance out and stop the yo-yo effect. We have the lowest overall operating margins of all major health care providers, and we are operating in an environment of drastic cost increases in terms of the key building blocks of labor, energy, liability and technology.

You heard the question someone asked before, is it appropriate that Medicare subsidize Medicaid? Until we start sorting out that whole thing, we have no choice. Mark Miller was correct. We do make a sizable profit, but that goes to subsidize the Medicaid program, which we're underfunded about 13 percent across the country.

There are also ways to achieve the budgetary savings. A lot has been said about the 85 percent rule, and I won't dwell on it. All I can say is that our cost per day averages about $500 compared to $800, $1,000, or whatever. So, we're seeing—we see no diminution of care. Quite the contrary. We see the same at a much lower cost.

Secondly, what we—someone also talked about the therapy cap problem. We would suggest that—we're going through and doing our studies now. We would suggest that we'll have a system to offer to you in September or October, so we would also with CMS to move this therapy cap problem down the line. It is irresponsible to have a $1,780 cap for someone that needs incredible rehab therapy. So, we think that we can move in that way.

Third, we think that there are savings that should be incurred under what we call the 3-day hospital stay. It was a neck in the funnel effect a long, long time ago. We think that it's way past—outlived its usefulness. In fact, what we see is a discriminatory practice with the Medicare Advantage plans, because they have no 3-day stay. We do. They do not.

So as we move forward in taking a look at the Advantage plans as has been the focus, we find there are a lot of activities that we need to pass on to you and follow up with, both in terms of how we contract, how they're operated under, and the different circumstances in which those Advantage plans are working with us.

So, as I said, a lot of this has been said already today, and I'll try to stay on message and finish up by saying thank you very much.

[The prepared statement of Mr. Yarwood follows:]

Prepared Statement of Bruce Yarwood, President, American Health Care Association

Thank you, Mr. Chairman, and this Committee, for providing the long term care community such a timely and valuable opportunity to discuss the long term care profession's ongoing commitment to providing quality long term care and services, and your efforts, specifically, to foster a constructive, cooperative environment in which we can continue to work successfully together on behalf of our nation's most vulnerable population of seniors and disabled citizens.

I am Bruce Yarwood, President and CEO of the American Health Care Association, the nation's largest long term care advocacy organization. I am honored to be here today to speak on behalf of our nearly 11,000 member facilities nationwide, and the nearly 2 million caring employees who provide critical care and services to 1.5 million frail, elderly and disabled every day.

My 30 years in long term care provide me a unique perspective on the state of the profession, and how to best meet the needs of our patients and residents in the years to come. Over the course of those 30 years, I have been the operator of facilities in northern California; served as a public servant running California's Medicaid program, MediCal; served as President of the California Association of Health Facilities; and have had the pleasure of working with several of you on this committee here in Washington during my more than 18-year tenure with AHCA.

I have witnessed first-hand and been a part of many significant changes in the long term care profession since I began my career. The nursing home of the early 1970s and through the '80s and '90s primarily cared for chronically ill residents for long lengths of stay ranging from many months to several years.

Our 21st century nursing homes are developing to meet the specific needs of today's aging American, where choice and the need for specialized services are more defined. We're seeing developments in both brick and mortar and care services to provide an increased level of short-term rehabilitative care and services to a more clinically-complex patient—for an average of 25 days for the Medicare patient. During this time, I have also witnessed a positive shift in which care quality improvement programs—collaborative, successful and ongoing efforts between providers and Government—are focused upon delivering the highest quality patient-centered care available.

In the context of today's discussion, I would like to preface my comments and observations by stating that the long term care profession has made tremendous strides to improve the quality of care and the quality of life of the nearly three million Americans who require critical skilled nursing care and services every year. At no time in the long term care profession's recent history has the commitment to

quality been greater, and I am proud to sit before you today on our profession's behalf.

Progress has been achieved due to the fact the entire long term care stakeholder community—providers, regulators, lawmakers and consumers—has established a more productive 'culture of cooperation'—which is undoubtedly contributing to the rising care quality standards in America's nursing homes. It is this spirit of a private/public partnership with a collective mission for quality care where we have been able to move the needle on quality.

We must be aggressive in addressing the many quality challenges remaining—and objective in our assessment as to how best to move forward. There's far more to do, that's for certain, but we are extremely confident we are heading in the right direction. As we proceed, we must all ensure the entire stakeholder community is prepared to meet the growing complex care needs of the baby-boom retirees—who will inundate our long term care system in the years ahead.

Economic Stability—The Foundation of Quality Care

In order to continue these positive trends and make the necessary investments to prepare for this aging population our shared success, the long term care profession requires a platform of continued financial stability—and will be the primary determinant to meeting our collective quality improvement goals and objectives.

That link between stable funding and quality has been noted time and again—by former Secretary of Health & Human Services Tommy Thompson, former Administrator of the Centers for Medicare and Medicaid Services (CMS), Dr. Mark McClellan, and most recently CMS Acting Administrator Leslie Norwalk, whose article for this month's edition of *Provider* magazine states,

> *"Nursing home providers have been on the leading edge of this quality movement. Long before hospitals, doctors, home health providers, pharmacies, dialysis facilities and others came to the table, the nursing home industry was out front with Quality First—a volunteer effort to elevate quality and accountability. . . . Advancing Excellence in America's Nursing Homes launched last September . . . builds on the 2001 Quality First campaign and stresses the essential connection between quality, adequate payment for services and financial stability."*

As Ms. Norwalk pointed out, *Quality First* was the first nationwide, publicly articulated pledge by a community of health care providers to voluntarily establish and meet quality improvement targets. The hallmark of our effort has been raising the standards of accountability—and consumers, taxpayers, and lawmakers have every reason to expect Government resources to be utilized in a manner that supports the provision of high quality long term care for every American. We are proud of our progress thus far—and remain committed to sustained improvement for the future.

This increased focus on resident-centered care, actual care outcomes, increased transparency and public disclosure, enhanced stakeholder collaboration and the dissemination of best practices models of care delivery is paying off.

Key quality indicators tracked by the joint federal-provider Nursing Home Quality Initiative (NHQI) have improved since we stood with HHS and CMS officials to launch this pioneering program five years ago. Since that time, we have experienced improved pain management, reduced use of restraints, decreased number of patients with depression, and improvements in physical conditions such as incidents of pressure ulcers.

In addition, Mr. Chairman, satisfaction of patients and family members is a critical measure of quality. Just last week, *My Innerview, Inc*. released the second annual report based on an independent survey of nursing home patients and their families. The report, *2006 National Survey of Resident and Family Satisfaction in Nursing Facilities*, indicates that a vast majority (82%) of consumers nationwide are very satisfied with the care provided at our nation's nursing homes—and would rate the care as either excellent or good.

We have been able to achieve these positive advances due to our collective commitment to quality—and the Government's recognition of how critical economic stability is for our sector has enabled us to continue these trends.

Annual cost of living increases are integral to maintaining economic stability, and essential to the continued provision of quality care. Skilled nursing facilities have the lowest overall operating margins of all major health care providers, and we are operating in an environment of dramatic cost increases in terms of the key building blocks of labor, energy, liability and technology.

The Administration's recent budget proposal to freeze the SNF market basket update in the coming fiscal year, create a prescriptive annual decrease of the market basket, and totally eliminate reimbursement for Medicare bad debt, not only in-

fringes on Congress's authority to determine funding levels for the Medicare program, but would also siphon off more than $10 billion in funds over the next five years—the very funds utilized to sustain our quality improvement efforts.

Further, Mr. Chairman, to continue focusing solely upon Medicare margins in the nursing home sector does a disservice to those frail, elderly and vulnerable individuals who receive care and services in those facilities. Nearly 70 percent of our nation's nursing home patients rely on Medicaid to fund the 'around-the-clock' long term care and services required, a program that pays, on average, less than $6 an hour for critical around-the-clock care and services.

But Congress cannot accurately assess the long term care marketplace and patients' growing needs without considering the rampant Medicaid underfunding crisis. America's nursing homes lose an average of approximately $13 per Medicaid patient per day. This annual $4.5 billion loss translated into a negative Medicaid operating margin of 7.06% in 2006—an unfortunate situation that is expected to continue throughout 2007.

Cost-Efficient, Clinically-Appropriate Post Acute Care

In regard to the so-called Medicare "75% Rule," Mr. Chairman, we state our unequivocal support for your recent efforts to continue moving towards full implementation. It is the right policy at the right time, being implemented for all of the right reasons.

Skilled nursing facilities (SNFs) are clinically appropriate, cost-effective settings providing the highest quality care and rehabilitative services. It is essential to note that since implementation of the 75% Rule was re-initiated in 2004, no Medicare beneficiary has been denied access to care—and the Federal Government has saved hundreds of millions in taxpayer dollars.

Recently-introduced legislation to suspend implementation of the 75% Rule is contrary to the interests not only for patients, but also to U.S. taxpayers—who deserve to see Medicare resources spent in the most efficient, cost-effective manner possible. Suspending implementation also runs contrary to the recent changes in the SNF patient classification system (RUGs 53), which provides incentives for SNFs to more accurately assess, and provide quality care to the patients requiring higher intensity rehabilitation services—at significantly lower cost (more than $500 per day) than those same patients who receive care in inpatient rehabilitation facilities.

The Rule differentiates the truly high acuity patients who need the most intensive rehabilitation services provided in a hospital setting from those who could be cared for in other settings, like SNFs, at the same high level and quality—and at a significantly lower cost to the Medicare program. With these policies in place, it is illogical in the context of both care quality and fiscal prudence for either Congress or the Administration to take action which delays full implementation of the 75% Rule.

Therapy Caps—Cost Containment Not in the Interest of Patient Rehabilitation

After a Medicare beneficiary has exhausted their 100-day Part A coverage for rehabilitation and post acute care services, they may require additional clinically necessary therapy services—including physical or occupational therapies or speech, language pathology—which is covered by a Part B benefit.

Unfortunately, current policy places arbitrary limits—or a cap—on the amount of the vital therapy services that are covered under Part B—an annual cap of $1,780. Practically since the inception of the cap, Congress has seen the error in this policy and for the past two years has directed CMS to develop an exceptions process for patients requiring rehabilitation in excess of the cap. Though this exceptions process is in place, it is not intended to be a long term solution to this illogical payment ceiling.

In order to move away from an arbitrary "therapy cap" scenario, we have proposed and are working with Congress and the Administration to develop a permanent, condition-based payment system for Part B covered therapy services. Such a system should be crafted to ensure appropriate rehabilitation services are available to the frail and elderly receiving care in our nation's nursing facilities when they are required.

We encourage Congress to require CMS to engage in a condition-based therapy reimbursement pilot program for one full year, and then fully implement a similar system nationwide while maintaining the current exceptions process to protect Medicare beneficiaries.

Moving to a Diagnostic-Based Post Acute Payment System

At present, there is an excessively fragmented and irrational health care services payment structure. When it comes to post acute care, for example, we now have it backwards: our post-acute payment structure is tied to the institutional setting in which patients are placed—not to the patient and the services required.

CMS requires different patient assessment instruments for three of the four post-acute care provider categories, and requires each provider to be certified under separate criteria. CMS ensures patient safety and quality in each of these settings through vastly different regulatory structures. In addition, the physical settings in which patients receive care greatly differ—ranging from a patient's home to a nursing home to a hospital.

Most post-acute care providers, physicians and others involved in patient care believe in a hierarchy of acuity among the different settings, and assume patients with the highest acuity clinical needs will receive care in the highest acuity setting. Research as well as provider experience shows that different post-acute care settings sometimes serve similar patients. This overlap in patient populations can occur for legitimate non-clinical reasons or clinical reasons that are not measurable by research. Regardless, the overlap is sometimes inappropriate, and results in Medicare overpayment.

For certain diagnostic conditions, inpatient rehabilitation facility (IRF) and long term care hospital (LTCH) reimbursements are much higher than SNF payments. Some of this is clearly due to variations in severity of illness. Yet, because there are no common patient assessment tools or outcome measures across all settings, it is not possible to ascertain whether patients are being treated in the most appropriate setting—and whether resources are being allocated efficiently and appropriately.

AHCA strongly supported language in the *Deficit Reduction Act of 2005 (DRA)* that served as a first step in reforming the post-acute care payment system. As is currently being developed, we believe it is essential for CMS to develop a patient centered uniform screening and assessment tool for post acute care patients, and a uniform integrated payment system based on this comprehensive assessment tool focused not on the site where services are provided but, rather, on the needs of the patient.

But until CMS can finalize and apply a uniform system, it can do a better job of placing post acute patients in the most appropriate care settings. For example, AHCA supports the use of hospital discharge planning as a starting point to standardize post acute assessment tools.

For patients with prior hospital stays, CMS should continue to apply hospital discharge planning that is already required by law and regulations. AHCA also supports continued Quality Improvement Organization (QIO) review of the appropriateness of patient placement.

Conclusion

Mr. Chairman, at a time when the Administration and Congress are considering budget cuts in many essential health care programs, the first priority must be to ensure we spend existing resources wisely and efficiently—and in a manner that best serves our seniors, our taxpayers and our citizens at large.

With the imminent wave of long term care patients before us, I reiterate that we must work together cooperatively to establish a health care system—particularly for post acute and long term care—which is patient centered, not site-centered.

For the reasons I have outlined, Mr. Chairman, it is imperative for Congress to take action to address the many existing payment and regulatory inconsistencies for skilled nursing facilities to ensure that we are able to effectively meet the needs of our aging population and continue the positive quality trends we are seeing. The *Long Term Care Quality and Modernization Act of 2006 (HR 6199),* which was introduced in the 109th Congress, represents an important step toward establishing and nurturing a culture of cooperation—a legislative step we enthusiastically embrace and endorse. This legislation would encourage investment in capital improvements and health information technology, support the sustainability of a stable and well-trained workforce, require joint training and education of surveyors and providers, and implement facility-based training for new surveyors.

The bill would also enhance the role of nurse practitioners in the nation's nursing homes and amend current law to allow nursing facilities to resume their nurse aide training program when deficiencies that resulted in the prohibition of the training have been corrected, and compliance has been demonstrated.

On the front lines of care, Mr. Chairman, these proposals are significant, and they merit strong support.

And from the standpoint of common sense, what is best for our patients and, indeed, what is ultimately best for the future of our nation's health care policy, these proposals should be implemented as quickly as possible.

Each of us here today seeks precisely the same objective—which is to improve the quality of care received by every long term care patient in America, and to do so in a manner that helps us best measure both progress as well as shortcomings.

As I have noted, Mr. Chairman, improving care quality is a continuous, dynamic, ongoing enterprise. While we are enormously proud and pleased by our care quality successes, we acknowledge there is far more to accomplish. And from our profession's standpoint, there has never been a broader recognition of the importance of quality, or a broader commitment to ensure it continues to improve by working together.

Thank You.

Chairman STARK. Thank you.

Mr. BREZENOFF?

STATEMENT OF STANLEY BREZENOFF, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CONTINUUM HEALTH PARTNERS

Mr. BREZENOFF. Thank you, Mr. Chairman, other distinguished Members of the Committee. I thank you for the opportunity to testify before you today. I am the president of Continuum Health Partners, a major health care network in New York City that includes four distinguished teaching hospitals; Beth Israel Medical Center, St. Luke's and Roosevelt, Long Island College Hospital and the New York Eye and Ear Infirmary.

These hospitals are safety net hospitals, and they are distinguished in part by the extraordinary degree to which they provide care to New York's poor, uninsured and the elderly. Of Continuum's 123,000 inpatient discharges in 2006, nearly 65 percent were Medicare or Medicaid. Our emergency room visits, over a quarter of a million were more than 45 percent Medicare and Medicaid. Of our more than 600,000 clinic visits, over 80 percent were insured by Medicare and Medicaid.

We also have a total of 80 residency programs, and in 2006, trained and educated over 1,000 interns and residents. So, today I'm pleased to testify on behalf of both the Association of American Medical Colleges, which represents all 125 accredited medical schools and nearly 400 major teaching hospitals and health systems throughout the United States and the Greater New York Hospital Association, which represents nearly 300 hospitals and continuing care facilities in New York, New Jersey, Connecticut, and Rhode Island, including many academic medical centers.

Continuum is also a member of the American Hospital Association, and I want to strongly endorse the testimony delivered on their behalf earlier.

I don't have to tell you, teaching hospitals have a unique role in our nation's health care system. In addition to providing basic, primary health care services to their communities and Medicare beneficiaries, teaching hospitals have the additional societal responsibilities of providing education for all types of health care professionals, an environment in which clinical research can flourish, and highly specialized tertiary patient care and cardiac care as well as transplant services.

Because of this, teaching hospitals care for the nation's sickest patients with the most complicated conditions. Teaching hospitals also provide almost half of all inpatient care, and provide a huge amount of care for the poor and the uninsured. Indeed, in many communities, teaching hospitals through their ambulatory care clinics are the family doctor, particularly in low income commu-

nities where individual practitioners who accept Medicaid or provide care for the uninsured are few.

One of our essential missions, to teach the next generation of physicians, has never been more important. The Census Bureau has pointed out that the elderly, the number of elderly will double by 2030, and with this will come a sizable increase in demand for health care services. According to data from the National Ambulatory Medical Care Survey, patients aged 65 and older typically average six to seven physician visits a year.

If the annual number of physician visits continue at this rate, the U.S. population will make 53 percent more trips to the doctor in 2020 than in 2000, which means that we will need to produce many more physicians per year than we are producing now. This has enormous implications for health care policy, given the length of time it takes to train physicians, 2020 is virtually now, and we need to take action immediately.

Unfortunately, at a time when the missions of our teaching hospitals have never been more important, many of them are struggling financially. The 2004 aggregate operating margin for all major teaching hospitals was negative 8.3 percent, with the typical major teaching hospital having a negative 5 percent operating margin. This is why Federal payment policies affecting our nation's teaching hospitals are so important.

As you know, Medicare has two special payments for teaching hospitals, IME and Direct Graduate Medical Education payments. The IME medical payment accounts fully for the fact that teaching hospitals must treat more severely ill patients than other hospitals, and DGME are designed to make sure that Medicare pays its share of costs.

Unfortunately, the President's proposals, both statutory and regulatory, put our nation's teaching hospitals at risk. As the AHA has testified, the President's budget would cut $101 billion from the Medicare and Medicaid programs over 5 years. I want to talk about two proposals that solely impact teaching hospitals—the elimination of the Medicare indirect medical education programs, payments associated with treating Medicare managed care or Medicare Advantage beneficiaries, and the complete elimination of Medicaid funding for GME.

First, in regard to Medicare Advantage, the argument seems to be that in teaching hospitals, we are getting paid twice. It's an absolute falsehood. We barely get paid once. The truth of the matter is that it is the Medicare Advantage programs that have been insulated from declines in funding with the addition of the 2 percent adjustment that they were able to get. That funding is what ought to be looked at if in fact there is an issue of too much funding going in the direction of IME.

As I noted, our hospitals are operating on negative margins. To remove that and to protect the Medicare Advantage programs would be to turn logic on its head.

Thank you.

[The prepared statement of Mr. Brezenoff follows:]

Legislative Hearing on Payments to Certain Medicare Fee for Service Providers

Testimony to

United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

by

Stanley Brezenoff
President and Chief Executive Officer
Continuum Health Partners

May 15, 2007

My name is Stanley Brezenoff and I am president and chief executive officer of Continuum Health Partners. Continuum is the parent company of four distinguished voluntary teaching hospitals in New York City, including Beth Israel Medical Center, St. Luke's and Roosevelt Hospitals, Long Island College Hospital, and New York Eye and Ear Infirmary. Continuum's partners offer an incredible array of innovative clinical programs and groundbreaking research projects. These endeavors exemplify the standards of excellence that are the centerpiece of our mission to provide the highest quality, most compassionate care to our patients. Let me also say that Continuum Health Partners is at a pivotal juncture in its eight-year history. Since our formation in 1997, we have taken major steps to establish a partnership that capitalizes on the expertise of some of the greatest medical and surgical talents in the country. During this same period, we have developed and implemented organizational and financial strategies that are helping us sustain the advances we have made as a major health care provider in the New York metropolitan region.

I am pleased to have the opportunity to testify before the subcommittee on behalf of the Association of American Medical Colleges (AAMC) and Greater New York Hospital Association (GNYHA) about the importance of Medicare's special payments to teaching hospitals.

The AAMC represents all 125 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and 96 academic and scientific societies representing 109,000 faculty members. GNYHA is a trade association comprising nearly 300 hospitals and continuing care facilities, both voluntary and public, in the metropolitan New York area and throughout New York State, as well as New Jersey, Connecticut, and Rhode Island. GNYHA members include academic medical centers, major teaching hospitals, and community hospitals, many of which also have teaching programs.

Continuum is also a member of the American Hospital Association (AHA). ***I wish to endorse the AHA's testimony concerning the FY 2008 Inpatient PPS Proposed rule, the hospital payment cuts proposed in the president's FY 2008 Medicare budget, the 75 percent rule for rehabilitation services, and specialty hospitals. While not the subject of this hearing, I would also like to express the AAMC and GNYHA's strong support for reauthorization and expansion of the State Children's Health Insurance Program so that the United States can provide health insurance coverage for all of our children.***

The Role of Teaching Hospitals in Serving the Nation's Patients and Medicare Beneficiaries

Teaching hospitals have a unique role in our nation's health care system. In addition to providing basic health services to their communities and Medicare beneficiaries, such as primary and secondary patient care, teaching hospitals are also responsible for providing education for all types of health care professionals; an environment in which clinical research can flourish; and highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services. Because of their education and researc

missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. As shown in the attached graphs, teaching hospitals tend to provide more advanced and specialized services than non-teaching hospitals.

Providing almost half of all inpatient care, teaching hospitals also provide a significant amount of charity care. Indeed, our nation's teaching hospitals provide large amounts of ambulatory care in area communities often acting as the "family doctor" in areas where few individual practitioners exist, accept Medicaid as a form of payment, or provide charity care. Most recently, major teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Not only are teaching hospitals invaluable providers of care, but teaching hospitals and their affiliated medical schools are major contributors to our nation's economy. According to "The Economic Impact of AAMC-Member Medical Schools and Teaching Hospitals" conducted by consulting firm Tripp Umbach, the nation's allopathic medical schools and teaching hospitals represented by the AAMC had a combined economic impact of $451 billion on their states and the nation in 2005, employ nearly 1,670,000 individuals, and are directly and indirectly responsible for more than 3 million full-time jobs—one out of every 48 wage earners in the United States.

Our mission to teach the next generation of physicians has never been more important. Indeed, according to the U.S. Census Bureau, the number of elderly will double by 2030. With this will come a sizable increase in demand for health care services. According to data from the National Ambulatory Medical Care Survey, patients aged 65 and older typically average six to seven physician visits per year. If the annual number of physician visits continues at this rate, the U.S. population will make 53 percent more trips to the doctor in 2020 than in 2000, which means that we will need to produce many more physicians per year than we are producing now. The Health Resources and Services Administration's (HRSA) Bureau of Health Professions projects that the nation will have a shortage of at least 55,000 physicians by the year 2020. This has enormous implications for health care policy. Indeed, given the amount of time it takes to educate and train a physician—four years of medical school, plus multiple years of residency training—2020 is now, and we must take action immediately. In fact the Federal Council on Graduate Medical Education (COGME) issued a report in 2005, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, that recommended that medical school enrollment be increased and that the cap on resident positions supported by the Medicare program be increased.

Medicare Special Payments to Teaching Hospitals

For 40 years, Medicare has played a critical role in ensuring that the important services provided by teaching hospitals are available to Medicare beneficiaries and other patients. AAMC teaching hospitals provide a disproportionate amount of health care services for

Medicare beneficiaries. Accounting for approximately 8 percent of all PPS hospitals, nearly one-fifth of all Medicare discharges (a total of 2 million discharges) are from AAMC teaching hospital members, also known as the Council of Teaching Hospital and Health Systems (COTH). Moreover, many of these Medicare patients are sicker and have more complicated illnesses. The average Medicare case mix index for AAMC COTH hospitals is 1.7 versus 1.5 for other teaching hospitals and 1.3 for non-teaching hospitals.

Medicare has recognized and provided its share of financial support to teaching hospitals for their unique roles extending beyond the traditional patient care service mission. Such payments include the Indirect Medical Education (IME) Adjustment, Direct Graduate Medical Education (DGME) and Disproportionate Share Hospital (DSH) payments.

The Indirect Medical Education Adjustment

In recognition that the additional missions of teaching hospitals increase the operating cost of patient care and that differences exist in operating costs between teaching and non-teaching hospitals, the Medicare program includes a special payment adjustment in its prospective payment system (PPS) known as the IME adjustment. Unfortunately, the IME adjustment is mislabeled and frequently misunderstood. While its label has led many to believe this adjustment to the diagnosis-related group (DRG) payments compensates teaching hospitals solely for the indirect costs associated with graduate medical education, its purpose is much broader. Both the House Ways and Means Committee and the Senate Finance Committee identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts…about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents….The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, No. 98-25, March 4, 1983 and Senate Finance Committee Report, No. 98-23, March 11, 1983).

Specifically, teaching hospitals receive an IME payment for every Medicare patient they treat. The IME adjustment is a percentage add-on to the basic DRG amount. A given hospital's IME payment is determined by its individual intern/resident-to-bed (IRB) ratio and a nationwide adjustment factor. The adjustment factor is established (and has been changed periodically) by Congress. In FY 2008, each DRG payment a hospital receives will be adjusted upwards from its basic rate by approximately 5.5 percent for every 10 residents per 100 beds in that hospital. The Balanced Budget Act of 1997 (BBA) initiated the start of a multiyear 30 percent across-the-board reduction in the IME adjustment, from 7.7 percent to 5.5 percent.

The BBA also made changes in how residents are counted for the IRB, a key variable in the IME formula. A limit was placed on the number of full-time equivalent (FTE) residents in allopathic and osteopathic training programs that a hospital can count for

purposes of receiving IME payments in either a hospital or non-hospital setting. In general, the number of residents can not exceed the number of residents counted during the hospital's most recent cost report period ending on or before December 31, 1996. Beginning in FY 1998, hospitals are permitted to count residents in a non-hospital setting for IME payment purposes if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Medicare Direct Graduate Medical Education Payments
Medicare also helps offset its share of the direct costs of educating medical residents through the DGME payment. DGME payments are based on the costs associated with residents' stipends and fringe benefits, the salaries and fringe benefits of faculty who supervise residents, other direct costs, and allocated overhead costs. Other direct costs include the costs of clerical personnel who work exclusively in the GME administrative office or other directly assigned costs.

From 1965 until 1985, Medicare paid for its share of DGME costs based on each hospital's historical "Medicare-allowable" DGME costs. Reimbursement was open-ended: if a hospital increased its DGME costs, the Medicare program would pay its share of the allowable costs incurred.

However, in April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), which dramatically changed the DGME payment methodology in two ways. Under this new method, Medicare pays hospitals its proportionate share of a hospital-specific capitated, or per resident, amount. In addition, the Medicare program limits the number of years for which it fully supports its share of residency training, with hospitals that train residents in subspecialty residency programs receiving only 50 percent of the Medicare DGME payment.

To determine the per resident payment amount, a hospital calculates its base year (usually FY 1984) Medicare-allowable DGME costs, and divides that figure by the average number of FTE residents present in all areas of the hospital complex in that year. The per resident amount is then updated from the base year using the Consumer Price Index (CPI) and multiplied by the number of residents in the payment year. Medicare's share of this total dollar figure is calculated by multiplying it by the ratio of Medicare inpatient days to total inpatient days. There are some important details concerning how the FTE resident count is determined, several of which I will discuss later.

Like the IME payment, there is a cap on the number of residents for which a hospital may receive DGME payments.

Disproportionate Share Hospital Payments
Because of the special missions of academic medical centers and teaching hospitals, many serve a disproportionate share of low-income individuals and thus receive Medicare Disproportionate Share Hospital Payments (DSH). Congress established such payments in the 1980s to recognize the higher costs incurred in treating a disproportionately high number of low-income patients and to ensure access to care for

Medicare patients. DSH payments are intended to support those hospitals that provide a disproportionate amount of care to the poor and are available only if a threshold "disproportionate share patient percentage" is met or exceeded. The current formula used to calculate the disproportionate share patient percentage is based on the amount of care provided to patients who receive Medicaid and Supplemental Security Income benefits.

In addition to the disproportionate share patient percentage, the level of Medicare DSH that hospitals receive is based on their status as an urban or rural provider and their bed count. Specific formulae are used to calculate DSH payments as percent add-ons to Medicare DRG rates. These formulae and the qualifying patient percentages were modified by Congress in 2000 and in 2003 to create greater equity among urban and rural providers.

The Financial Picture for Major Teaching Hospitals

The missions of teaching hospitals have important financial consequences. Thus, it is not surprising that the aggregate total margin for the nation's major teaching hospitals is consistently and significantly below that of other hospital groups. In some years, the margins have hovered near zero. In 2004, the most recent and complete data available, the aggregate total margin for major teaching hospitals (those with an intern/resident-to-bed (IRB) ratio of 0.25 or more) was only 3.4 percent; half of teaching hospitals had total margins less than 2.4 percent. By contrast, the aggregate total margin for other teaching hospitals was 5.0 percent, and 4.7 percent for non-teaching hospitals.[1]

Total margins often reflect the "best-case" scenario for hospitals because they reflect revenues associated with non-patient care activities. Operating margins reflect a much bleaker picture for major teaching hospitals. The 2004 aggregate operating margin was -8.3 percent, with the typical major teaching hospital having a -5.0 percent operating margin (the average was -10.5 percent). By contrast, other teaching and non-teaching hospitals had aggregate operating margins of 0.6 percent and 1.5 percent respectively.

Hospital Total and Operating Margins, by Teaching Status, 2004

	Total Margin			Operating Margin		
Hospital Type	***Aggregate***	***Average***	***Median***	***Aggregate***	***Average***	***Median***
Major Teaching	3.4%	1.5%	2.4%	-8.3%	-10.5%	-5.0%
Other Teaching	5.0	2.9	3.6	0.6	-1.5	-0.6
Non-Teaching	4.7	2.5	3.3	1.5	-2.0	-0.5

Source: Vaida Health Data Consultants, Analysis of Medicare HCRIS Database, June 30, 2006 Update

[1] 2004 Margin Analysis conducted by Vaida Health Data Consultants (using the June 30, 2006 HCRIS Update). Unless otherwise indicated, all margin figures were obtained from this analysis.

The special payments made by Medicare to teaching hospitals help ensure the hospitals' financial viability. Thus, it is not surprising, and is quite consistent with the missions of these payments, that Medicare margins for major teaching hospitals are higher than for other groups. In addition, because the primary purpose of Medicare DSH payments is to help offset the costs associated with uninsured patients rather than Medicare patients, we believe that these payments should be excluded when calculating Medicare inpatient and Medicare overall margins. When these payments are removed, both aggregate Medicare inpatient and overall margins for major teaching hospitals are significantly reduced.

Hospital costs and cost growth are key components when assessing hospitals' financial conditions. Because of their fragile overall financial conditions, major teaching hospitals must be diligent about resource spending. Despite unprecedented cost pressures, major teaching hospitals have been able to constrain their cost growth below that of other hospital groups. Between 2000 and 2004, Medicare operating costs per case (adjusted for case mix) grew an average of 5.5 percent for major teaching hospitals, compared to a growth of 6.4 percent for other teaching hospitals, and 6.6 percent for non-teaching hospitals.[2]

Ensuring Adequate Medicare Resources for Teaching Hospitals, Their Medicare Patients, and Communities

Teaching hospitals provide important societal missions on razor-thin margins. It is critical that policymakers and academic leaders work together to ensure, as was promised in 1965, that Medicare continues to support the vital missions of teaching hospitals that represent the cornerstone of America's health care delivery system. The AAMC and GNYHA therefore call upon the Congress to commit to protect these vital and critical [illegible] working with us on implement the following agenda.

1. Oppose the President's FY 2008 Medicare and Medicaid Budget Proposals Th Cut Teaching Hospital Payments

The president's FY 2008 budget proposes to cut $101.5 billion from the Medicare and Medicaid programs over five years. President Bush's Medicare budget proposes $76 billion over five years in legislative and regulatory cuts from hospitals and other providers, including approximately $14 billion in inpatient and $3 billion in outpatient reductions. All of the proposals that would negatively affect hospital payments are of concern to teaching hospitals. We commend and join Representatives Richard Neal (D Mass.), Phil English (R-Pa.) and 221 other members of Congress who have urged the House Budget Committee leaders to reject cuts to Medicare and Medicaid hospital funding in the FY 2008 budget resolution.

Two specific proposals solely affect teaching hospitals: the elimination of teaching hospitals' Medicare IME payments associated with treating Medicare Advantage beneficiaries and the elimination of Medicaid funding for graduate medical education.

[2] AHA analysis of Medicare operating cost [illegible] growth, using the March 31, 2006 HCRIS Up

Teaching Hospital Medicare IME Payments Associated with Treating Medicare Advantage Enrollees

Included in President Bush's Medicare budget is a legislative proposal to "eliminate duplicate IME payments to hospitals for MA beneficiaries." The proposal would eliminate IME payments that are made directly to teaching hospitals when they care for Medicare Advantage (MA) enrollees.

The BBA of 1997 established mechanisms to directly reimburse teaching hospitals for DGME and IME payments associated with Medicare managed care patients to prevent the degradation of the academic medicine infrastructure under managed care. These payments were financed by "carving out" the payment from the managed care rates.

Teaching hospitals are between a rock and a hard place in a managed care environment because the economic imperative for managed care plans is either to negotiate lower teaching hospitals' rates by excluding payments for DGME and IME or contracting with lower cost non-teaching hospitals wherever possible. Either way, teaching hospitals would lose by accepting inadequate payments to hold onto their business or by losing the business to lower-cost non-teaching hospitals.

The BBA anticipated this problem when it created the Medicare+Choice program, the precursor to MA, by calling for the separate payment of the DGME payment and IME payment to teaching hospitals for HMO enrollees, thus removing the issue of teaching hospitals' higher costs from the negotiating table and ensuring the integrity of the nation's training and biomedical research infrastructure. In 2002, MedPAC supported this mechanism in its *Report to the Congress: Medicare Payment Policy.*

However, when Congress set MA plan rates with the enactment of the Medicare Modernization Act of 2003, it added back IME payments to the MA benchmark payment rates.

The president's proposal is based on the premise that the IME payment is being paid twice in the Medicare Advantage program-- once to health plans in their rates and once directly to teaching hospitals. Instead of returning to the BBA's original concept—namely, a "carve out" from plan premiums—the president's budget proposal eliminates the direct payments to teaching hospitals. It should be underscored that teaching hospitals are not receiving the IME twice. This is because the law requires noncontracted hospitals to accept as payment in full the amount that Medicare would have paid through fee-for-service (FFS) rates, effectively capping any hospital's MA payment at the FFS equivalent.[1] If a hospital has a contract with an MA plan, its payment is often less

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[1] 42 C.F.R. §422.214(b) states: "(a) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the [Social Security] Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare." (Section 412.105(g) concerns indirect medical education

because the health plan can often negotiate down from this fee-for-service cap. This is because if the "worst" that could happen to a plan when a hospital is not in a health plan's network is that the plan has an obligation to pay the fee-for-service amount less IME payments, health plans have no reason to pay more to persuade a hospital to contract with it.

If President Bush's budget proposal were to be enacted, it would strip away the IME payment made directly to teaching hospitals, causing losses in the nation's teaching hospitals of more than $600 million per year. Teaching hospitals might try to negotiate higher payments from MA plans to make up for the loss, but would probably be unsuccessful because of the dynamics and economic pressures of the negotiated rate market described above.

We oppose this proposal and urge Congress to protect these much-needed payments to teaching hospitals. If Congress is seeking savings from the Medicare program, we believe that one source of legitimate savings would be to remove IME payments from the MA rates, while continuing to make IME payments directly to teaching hospitals when they serve MA enrollees.

Medicaid's Support for Graduate Medical Education

The AAMC and GNYHA realize that this committee does not have jurisdiction over the Medicaid program. However, in light of the committee's interest in the viability of teaching hospitals and the safety net, we want to ensure that the committee is aware we are opposed to the president's Medicaid proposal that "clarifies" that Medicaid "will no longer be available as a source of funding for [Graduate Medical Education]." This proposal is estimated to save $1.8 billion over 5 years.

Many state Medicaid programs have long recognized the need to make additional payments to teaching hospitals to help offset additional costs these facilities incur as a result of their special missions of educating physicians and caring for patients who require more intense, complex care. Following Medicare's lead, many states have implemented two payments similar to Medicare's IME adjustment and DGME. Such payments are not intended to offset the full level of additional costs incurred by teaching hospitals, but instead pay Medicaid's "share" of these costs. According to a study commissioned by the AAMC, in 2005, 47 states and the District of Columbia provided DGME and/or IME payments under their Medicaid programs. The nation's major teaching hospitals provide a disproportionate amount of health care services for Medicaid beneficiaries and the uninsured, while simultaneously maintaining core missions of medical education, biomedical research, and innovative patient care. Approximately 24 percent of all Medicaid discharges are from major teaching hospitals. Major teaching hospitals provide nearly one-half (45 percent) of all hospital charity care.

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payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direction medical education costs.)"

Given these times of increasing financial uncertainty for America's teaching hospitals, ***it is important that the Medicaid program and states be allowed to maintain their financial commitments to teaching hospital missions.*** We appreciate Congress' desire to intervene by including in HR 2206, the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 a one-year moratorium of the implementation of this proposal.

2. Reject the Medicare Payment Advisory Commission's March 2007 IME Recommendation

On March 1, 2007, the Medicare Payment Advisory Commission (MedPAC) released to Congress its *2007 Report to the Congress: Medicare Payment Policy*. The teaching hospital community was extremely distressed that MedPAC adopted the following recommendation in its *Report*:

> Concurrent with implementation of severity adjustment to Medicare's diagnosis group related payments, the Congress should reduce the indirect medical education adjustment in fiscal year 2008 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained from reducing the indirect medical education adjustment should be used to fund a quality incentive payment system.

We appreciate and share the Commission's desire that the diagnosis-related group (DRG) system be modified to better reflect patient severity. Major teaching hospitals tend to treat the sickest and most complex patients. Providing Medicare payments that more closely align with the higher costs of treating these patients makes sense from both policy and practical perspectives.

We are concerned, however, about linking an IME payment reduction with this change. First and foremost, the overall financial condition of major teaching hospitals does not support any reduction in IME payments. Also, reducing the IME by one percentage point from 5.5 percent to 4.5 percent represents a 20 percent reduction in total IME payments.

Second, MedPAC's recommendation to reduce IME payments is premised on implementation of a severity adjustment. As you know, CMS has not implemented such an adjustment but has only recently proposed an overhaul of the current DRG system by creating 745 new Medicare-severity DRGs to replace the current 538 DRGs. We are currently reviewing the impact of this proposal and it is not yet known to what extent such a system will fully address patient severity cost differentials.

Moreover, CMS has recently implemented, or is considering implementing, a number of other changes to the DRG system that will, or could have, a significant impact on teaching hospitals. These include adding an occupational mix adjustment to the hospital wage index, other changes to wage index policies, and altering the standardization process when setting DRG weights.

We believe that MedPAC's recommendation to reduce the IME adjustment is, at best, premature. For these reasons, the AAMC and GNYHA urge Congress to reject the MedPAC recommendation.

3. Lift Medicare's Resident Limits

Section 4621 of the BBA limited the number of allopathic and osteopathic medical residents that could be counted for purposes of calculating teaching hospitals' Medicare IME and DGME reimbursement. In general, effective October 1, 1997, to the extent the number of allopathic or osteopathic residents being trained at teaching hospitals exceeds their 1996 limits, teaching hospitals receive no additional IME or DGME payments. Podiatry and dental residents are excluded from the resident limits.

The academic medicine community understood at the time the BBA was passed and signed into law that Congress was establishing a cap on the number of physician residents that would be countable for Medicare DGME and IME purposes for two reasons. One reason was so the teaching hospital community, like many others, could contribute toward bringing about a balanced budget. The other reason was to address the conventional wisdom of the early to mid-1990's regarding an impending oversupply of physicians. This conventional wisdom was predicated in large part on reports that had been published in the early 1990s by the COGME, a body that advises Congress and the U.S. Department of Health and Human Services on GME and the physician workforce.[4] Independent research conducted by health economists and policy experts, including the Institute of Medicine, generally supported these findings. Thus, in deciding to include the resident cap provision within the BBA, Congress sought to significantly limit the production of physicians and respond to the then-conventional wisdom regarding a looming physician oversupply.

Section 407 of the Balanced Budget Refinement Act of 1999 (BBRA) increased the limit for rural teaching hospitals to equal 130 percent of each rural teaching hospital's 1996 resident count and Section 422 of the Medicare Modernization Act of 2003 created a one-time program to reduce the Medicare resident caps for hospitals with below-cap resident counts and "redistribute" them to hospitals seeking to expand their caps.

Despite the cap adjustment for rural teaching hospitals, and the 2005 implementation of the resident limit redistribution program, the BBA's overall resident limit policy continues to impose significant limitations on the ability of teaching hospitals and medical schools sponsoring and conducting graduate medical education programs to respond to the needs of the communities they serve. The growth and aging of our population now indicate a very different future. According to the U.S. Bureau of the Census, the elderly population in the U.S. is expected to *double* between 2000 and 2030. Because of this rise in the number of elderly and a number of other factors, demand for

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[4] See, in particular, *Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century* (COGME Third Report, October 1992) and *Recommendations to Improve Access to Health Care Through Physician Workforce Reform* (COGME Fourth Report, January 1994).

physician visits is expected to increase by 53 percent between 2000 and 2020, according to an analysis performed by the AAMC using data gathered from the National Ambulatory Medical Care Survey. Currently, the vast majority of health policy analysts and physician workforce researchers have concluded that the forecasts made 10 years ago were in error because they were based upon the presumption that the entire US health care system would change due to managed care. In fact, many states and physician specialties are reporting current shortages.

Clearly, the current limitations on the number of residents Medicare will support ignores current and future physician shortages experienced in many states and in many specialties. COGME issued a report in 2005, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, recommending that medical school enrollment be increased and that the cap on resident positions supported by the Medicare program be increased. The COGME report's analysis indicated that while the supply of physicians is expected to increase over the next two decades, demand for services is likely to grow even more rapidly. According to the report, the three major factors driving the increase in demand will be the projected U.S. population growth of 18 percent between 2000 and 2020, the aging of the population as the number of Americans over 65 increases from 35 million in 2000 to 54 million in 2020, and the changing age-specific per capita physician utilization rates, with those under age 45 using fewer services and those over age 45 using more services. The report notes that changing work patterns of physicians, such as decreases in working hours, could lead to greater shortfalls, while increases in productivity may moderate any shortfalls. As a result of the overall trends, however, the report recommended an increase in U.S. medical school production by 15 percent and noted, "the current cap on the number of residents and fellows eligible for Medicare reimbursement strongly discourages teaching hospitals from increasing the number of residents."

In October of 2006, the HRSA's Bureau of Health Professions issued a report examining the physician workforce through 2020.[5] This report suggested that, by 2020, the number of primary care physicians will grow 18 percent while demand for their services are likely to grow somewhere between 20 percent and 30 percent. While HRSA has historically focused on access to primary care services, they suggest an even larger shortfall of non-generalist physicians. By 2020, the number of non-primary care physicians will grow by about 10 percent while demand for their services—driven largely by the elderly—will grow between 25 percent and 45 percent, leaving a shortfall which will not be met without expanding the physician workforce and concurrently improving the efficiency of care delivery.

Because of physician workforce needs and the commitment to their educational missions, states, medical schools, and teaching hospitals are already beginning to respond to the nation's physician shortage needs by creating new medical schools or expanding medical school class size, expand[illegible] residency programs or creating new ones. The AAMC is calling for a 30 percent increase in medical school enrollment over the next decade, a[illegible]

AAMC surveys of U.S. medical school deans indicate that most growth will occur in public institutions and in those states where population growth has far outpaced the infrastructure for medical education. In addition to M.D. granting schools, osteopathic schools are also planning increases. New and existing D.O. schools are expected to increase enrollment by 2,000 to 3,000 per year over the next decade.

Teaching hospitals have increased the number of residents they train beyond their 1996 caps in accordance with greater need for current and future physician services. According to AAMC analysis, based on 975 teaching hospitals reporting both cap and count data on FFY 2004 Medicare cost reports, 464 hospitals are over their resident caps by an aggregate count of about 4,900 positions. These hospitals receive no Medicare IME or DGME support associated with these additional residents.

Given the extended time required to increase U.S. medical school capacity and to educate and train physicians, the nation must begin now to increase medical school and GME capacity to meet the needs of the nation in 2015 and beyond when demand for services are expected to outstrip physician supply. A shortage of physicians would undeniably make access to care more problematic for all citizens, particularly those that are already underserved. Such shortages would increase the delays individuals encounter in scheduling appointments and the distances they will need to travel for various types of health care services. Shortages would be especially problematic for the disadvantaged who already encounter substantial barriers to health care services. Congress must do its part to recognize the current and future needs for more physicians and pass legislation to eliminate the Medicare resident cap.

4. Congress Should Work With CMS to Clarify in Statute That the Medicare Program Is Intended to Support All Resident Training Time

The academic medicine community has come under increasing pressure from policymakers to take a greater leadership role in educating and training physicians who are able to respond to the various challenges presented by an increasingly diverse and complex health care system. For example, there has been increasing focus in recent years on cultural and linguistic issues in the delivery of health care and how the relatively little attention given to these matters in the physician education curriculum might be a contributing factor to disparities in health care outcomes. In addition, more and more treatments are available on an outpatient basis as a result of significant biomedical advances and this has created a need for alternative training settings outside the traditional acute inpatient unit.

Medical schools and teaching hospitals have responded to these demands for change by incorporating a variety of new educational strategies into their curricula so that physicians-in-training are better prepared to address these issues. The Accreditation Council for Graduate Medical Education, which accredits all allopathic physician residency training in the U.S., has incorporated six core educational competencies within the accreditation requirements for all training programs and has modified specialty requirements to ensure that appropriate experience in the outpatient setting is included. In

order for teaching hospitals and residency programs to maintain their accreditation (and receive Medicare reimbursement), they must ensure that special educational seminars, workshops, lectures and other didactic strategies are included as part of the curriculum, and that residency training activities occur in a variety of settings. The AAMC and GNYHA support this movement as it only serves to improve the preparation of tomorrow's physicians.

Unfortunately, CMS's Medicare DGME and IME regulations regarding physician training in nonhospital settings and treatment of educational (other than direct patient care) activities are creating disincentives for exactly the kind of educational strategies that policymakers want the academic medicine community to promote.

In recent years, much to the dismay of the academic medicine community, CMS has promulgated Medicare regulations that have had the unfortunate effect of disallowing certain legitimate physician resident training activities for purposes of Medicare direct and/or indirect medical education reimbursement. In addition to these financial penalties, the effect of these complex regulations has been to add to the already significant administrative burdens on teaching hospitals.

The AAMC and GNYHA have forcefully expressed their disagreement with CMS's view that the Agency is required under the statute to assess the exact nature of particular physician resident activities. The practical reality is that physician resident training is a fluid activity that comprises direct patient care, educational activities related to patient care, and research activities intended to support patient care. Except in certain specific and very limited cases (e.g., a defined special research assignment that is separate and apart from the ordinary course of education and training), the activities blend together to form a seamless whole that is not amenable to the parsing that the Agency seeks to impose. And we believe in particular that this parsing was never intended or expected by Congress. The Agency has generally indicated that they are simply "implementing Congress's intent" and that the Agency is "bound by the language in the statute." For this reason, the AAMC and GNYHA urge Congress to work with CMS to set clear and simple rules that will allow Medicare GME reimbursement in the manner in which the academic medicine community believe it was intended. Following are descriptions of several CMS policies that seek to parse physician resident time, and an example of how the Agency seems to be expecting the time to be tracked for Medicare reimbursement purposes.

Training in Nonhospital Settings

In recognition of the importance of residency training in ambulatory sites, Congress authorized teaching hospitals to receive DGME and IME payments associated with residents training in nonhospital sites, such as physicians' offices, if they incur "all or substantially all" of the training costs. In 1999, CMS issued a regulation defining "substantially all" of the training costs as the residents' stipends and benefits plus physician supervisory costs

CMS recently finalized a regulation that is intended to make it administratively easier for teaching hospitals to count the time that residents spend in nonhospital settings. While the academic medicine community appreciates CMS's efforts to simplify matters, the regulations still involve a significant documentation burden associated with tracking this time. More fundamentally, we vigorously disagree with CMS's interpretation of the statutory "all or substantially all" requirement because the regulations fail to recognize that many supervising physicians volunteer their time. This failure on the part of CMS to recognize the nature of physician voluntarism is what causes the bulk of the administrative burden that is associated with this particular policy.

The academic medical community has a long tradition of physician volunteers. We believe that through negotiation the hospital and nonhospital site should determine whether there are supervisory costs and, if so, the level of those costs. Further, if physicians state they are volunteering as supervisors, CMS should not require hospitals to pay supervisory costs. We urge Congress to clarify the definition of "all or substantially all" training costs at the nonhospital site to mean the stipends and benefits provided to the resident and other amounts, if any, as determined by the hospital and the entity operating the nonhospital setting. We commend Reps. Kenny Hulshof (R-Mo.) and John Tanner (D-Tenn.) for their leadership in sponsoring past legislation entitled "the Community and Rural Medical Residency Preservation Act" that would do just that.

Engaging in Educational Activities

In the federal fiscal year 2007 IPPS proposed rule, CMS sought to "clarify" the agency's position that it does not provide Medicare IME reimbursement for educational activities such as conferences, seminars, and workshops in any setting and does not provide Medicare DGME reimbursement for these activities if they are held in a nonhospital (e.g., affiliated medical school) setting because these activities are not "related to patient care." This so-called clarification came as a shock to the academic medicine community, so much so that CMS received more than one thousand comment letters objecting to the proposal. The comments reminded CMS that didactic activities are an integral component of the patient care activities engaged in by residents during their residency programs. Moreover, the nature of physician residency training is that these educational activities are intertwined throughout the physician residency training experience and cannot be separated as CMS seemed to believe that they could. In the 2007 IPPS final rule, CMS responded by reiterating that these activities were not reimbursable, but that teaching hospitals could invoke a "one-day documentation threshold."

This means that hospitals would not be required to keep track of didactic activities that were less than a day in length. However, according to CMS, if hospitals do maintain resident documentation at a detailed level or on audit the fiscal intermediary "comes across" such activities, the time will be excluded from the resident FTE count.

Vacation and Sick Leave

In a continuation of its efforts to exclude resident time that is not directly related to treating patients, as part of the federal fiscal year 2008 IPPS proposed rule now in the comment period, CMS has gone still further and clarified that vacation and sick time

should not be countable at all when considering resident time. That is, not only should it not be reimbursable by Medicare (removing it from the numerator), it should not be considered countable time at all (removing it from the denominator). While the AAMC and GNYHA are grateful that it is being removed from both the numerator and denominator, we are extremely frustrated at yet another case of micromanaging the exact nature of physician resident "time" and what category it falls into and how it should be treated. The AAMC and GNYHA will be submitting comments to CMS expressing our frustration that so much time and energy is being spent engaging in this kind of parsing when the academic medicine community is simply seeking to have each physician resident be considered as one full 100 percent FTE when calculating direct GME and IME payments (notwithstanding that resident fellows are counted as a 0.5 FTE for other reasons when determining direct GME payments).

Example of How All This Time Would Need to be Tracked

To illustrate the inherent complexity of physician resident activities and the onerous administrative expectations by CMS for hospitals to track the time associated with these activities, consider the example of a physician resident training in her second year of an internal medicine program. In the course of one week, the resident may spend the bulk of her time training on a medical-surgical inpatient unit in a hospital with one afternoon set aside for going to a physician's office to see patients for primary care visits, one morning set aside for a morbidity and mortality (M&M) conference, and she may also have the misfortune of needing to call in sick one day. The teaching hospital would like to simply note that all this time counts as one full week of reimbursable time. Previously, this would have been generally acceptable. Now, however, the hospital would seemingly be expected to:

- determine the actual number of days and hours that the resident was performing any training activities in the week (this is to determine the denominator from which to start subtracting time);
- determine whether any of the time may be viewed as voluntary and not part of the approved program (e.g., going to the library to study);
- subtract out the sick day (or hours) from the time to get a new denominator to start from;
- subtract out the scheduled M&M conference time from the total number of hours for purposes of the IME count;
- determine whether the scheduled M&M conference took place in a nonhospital setting so that it can be subtracted from the direct GME count of time;
- determine whether the assignment at the physician's office is covered under a separate written agreement;
- determine whether the hospital has reimbursed the physician's office a CMS-approved amount in order to count the time at all; and
- determine whether any other nonpatient care activities took place in the hospital, at the physician's office, or at another nonhospital setting (e.g., an affiliated medical school).

The AAMC and GNYHA recognize that CMS's role is to ensure that its regulations reflect congressional intent, and if the statutory language is not exact enough to permit CMS to establish regulations that simplify this time tracking, the agency must sometimes make difficult distinctions. If the language within the statute needs further clarification and simplification to demonstrate Congress's intent that Medicare should fully support its fair share of the costs of training physician residents, we strongly urge Congress to do so so that the academic medicine community will no longer be weighted down with these severe administrative and documentation burdens.

The AAMC and GNYHA therefore recommends that Congress work with CMS to clarify in statute that the Medicare program is intended to support its fair share of all approved resident training time for both direct GME and IME.

5. Implement a Stable and Equitable Physician Payment Formula

While the focus of this hearing has been on hospital, home health, and skilled nursing facility payment systems, the AAMC and GNYHA want to reiterate that they are greatly concerned by the projected 10 percent reduction in Calendar Year (CY) 2008 Medicare physician payments. Unless Congress and the Bush Administration work together to resolve the fundamental flaws in the Sustainable Growth Rate (SGR) methodology used to calculate physician payment updates, the Medicare Trustees predict additional cuts of approximately 5 percent annually through CY 2016.

Under teaching hospitals' long-standing relationship with medical schools, medical school full-time clinical faculty ("teaching physicians") care for a large segment of teaching hospitals' inpatients and outpatients. Nationwide, over 97,000 teaching physicians have partnered with major teaching hospitals to provide a full range of clinical services, including cutting-edge care often unavailable elsewhere in the community. These same physicians also work with us to train medical students and residents; conduct clinical research that advances health care prevention, diagnosis, and treatment options; and provide health care for all Americans, regardless of their ability to pay for care.

Medicare physician payment cuts will exacerbate the ever-increasing financial pressure on teaching physicians to produce clinical revenue, which represents about one-third of total medical school revenue. One-quarter of that clinical revenue comes directly from Medicare. Our medical school partners will find it increasingly difficult to maintain their missions of medical education, clinical research, and patient care while facing reductions in Medicare reimbursement. It could also jointly affect our capacity to provide charity care and stand-by disaster readiness for the communities we serve.

The impact of Medicare physician cuts on teaching hospitals and our affiliated teaching physicians will be compounded further if community-based physicians restrict their acceptance of new Medicare beneficiaries or begin to limit access to less profitable Medicare services. Teaching hospitals and our teaching physician partners, which historically accept all patients regardless of their health coverage, would likely see an increase in our volume of Medicare patients, without receiving adequate reimbursement for Medicare services.

In light of the close relationships between teaching physicians and teaching hospitals across the country, we are very concerned by the immediate and direct impact Medicare physician payment reductions will have on our ability to maintain medical education, clinical research, and patient care missions.

We urge you to work with the administration to prevent the negative updates projected for the next few years, and we urge you to work with the physician community to implement a stable and equitable physician payment formula.

6. Support An IME Adjustment in Outpatient PPS

We urge Congress to ask CMS to conduct an analysis to determine whether an IME-type adjustment should be implemented in the outpatient PPS. Major teaching hospitals have negative Medicare outpatient margins significantly lower than those of other hospital groups,[6] indicating that the outpatient PPS may not appropriately reflect services provided and patients treated in teaching hospitals' emergency rooms and outpatient clinics. The outpatient PPS statute provides CMS with the authority to include an IME adjustment, and the recently implemented prospective payment systems for both psychiatric and rehabilitation facilities contain IME adjustments.

Conclusion

For 40 years, Medicare has played a critical role in ensuring that the important services provided by teaching hospitals are available to Medicare beneficiaries and other patients. We believe strongly that if Medicare's support for teaching hospitals further deteriorates or waivers, then the very missions that the teaching hospitals support will be in jeopardy. If teaching hospitals' patient care, research and educational infrastructure begins to falter, the effects will be extremely difficult to reverse. I thank you for the opportunity to testify today. The AAMC and GNYHA look forward to working closely with this Subcommittee on these issues, which are of such importance to the health and well-being of our nation's seniors and, indeed, all Americans.

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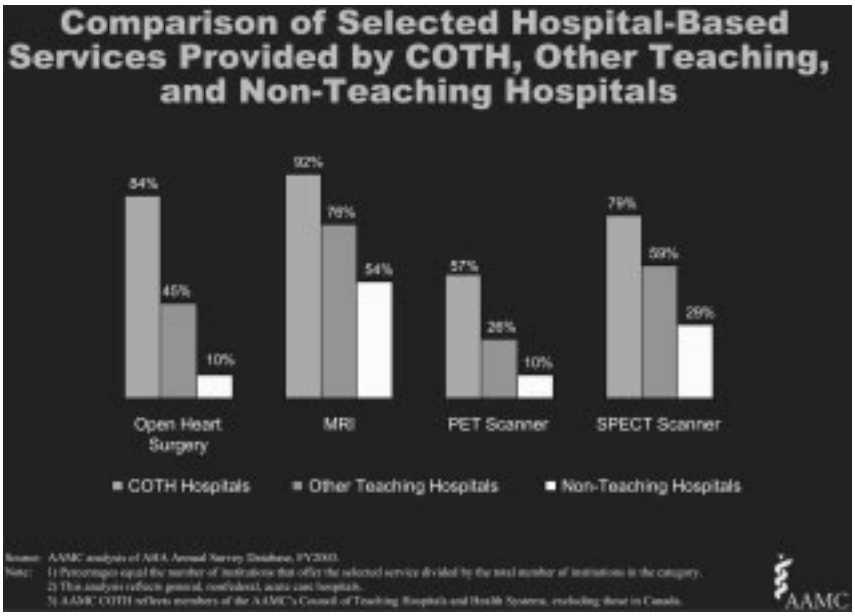
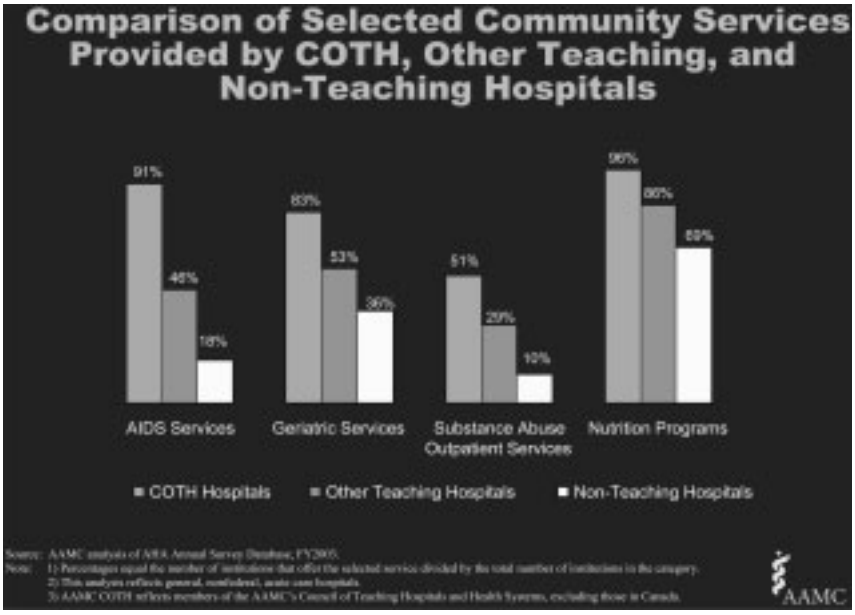
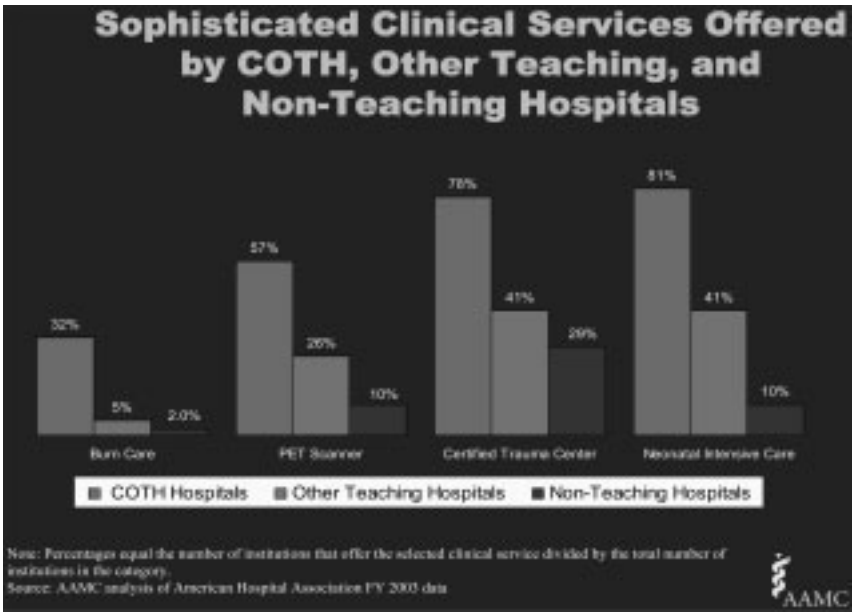
[6] In 2004, major teaching hospitals had a -17.5 percent aggregate Medicare outpatient margin, compared to -7.3 percent for other teaching hospitals, and -8.0 percent for non-teaching hospitals.


Comparison of Selected Hospital-Based Services Provided by COTH, Other Teaching, and Non-Teaching Hospitals
84%
45%
10%
92%
78%
54%
57%
28%
10%
79%
59%
29%
Open Heart Surgery
MRI
PET Scanner
SPECT Scanner
COTH Hospitals
Other Teaching Hospitals
Non-Teaching Hospitals
AAMC


Comparison of Selected Community Services Provided by COTH, Other Teaching, and Non-Teaching Hospitals
91%
46%
18%
83%
53%
36%
61%
29%
10%
96%
80%
69%
AIDS Services
Geriatric Services
Substance Abuse Outpatient Services
Nutrition Programs
COTH Hospitals
Other Teaching Hospitals
Non-Teaching Hospitals
AAMC



Chairman STARK. Ms. Chesny?

STATEMENT OF CHRISTINE CHESNY, NATIONAL ASSOCIATION FOR HOME CARE AND HOSPICE AND MICHIGAN HOME HEALTH ASSOCIATION

Ms. CHESNY. Thank you, Mr. Chairman, Ranking Member Camp and Subcommittee Members for inviting me to present testimony on issues related to payment accuracy and legislative and regulatory payment refinements for the Medicare Home Health Prospective Payment System.

My name is Christine Chesny. I am president of the Michigan Visiting Nurse Association, a not-for-profit provider of home health, hospice, home medical equipment, palliative care and private duty nursing services to 11 rural counties in the heart of Michigan. I am the past president of the Michigan Home Health Association and a finance Committee Member of the National Association for Home Care and Hospice.

The Prospective Payment System for Medicare Home Health is based on the right principles as it facilitates outcomes-oriented patient care planning that is focused on rehabilitation and self care. However the current Medicare Home Health Prospective Payment System has been found to be seriously flawed.

MedPAC states the system fails to fairly set rates in relation to the level of care in over 75% of the case categories, yet Medicare's recently proposed changes to PPS incorporate a presumption of—that we believe to be completely unfounded.

NAHC has strongly supported CMS efforts to restructure the system and to replace a poorly functioning case mix adjustment model.

However the CMS proposal assumes all increases in average case mix weight are entirely due to provider gains. To assume that any change is attributed to gaining assumes that nurses throughout the country are deliberately falsifying patient assessments to garner higher payments for their agencies.

Given our agency's experience, I believe the increase reflects the changing demographic of our patient population. First and foremost, they are older and more frail. In our agency in 2001, 24.9 percent of our patients were over age 80. In the most recently completed fiscal year that percentage has risen to 34.

In general the type of patient referred to us is more—requires more intense service and has increased significantly due in large part to hospital DRG policy changes leading to decreased length of stay and from changes in inpatient rehab facility reimbursement that have appropriately scared more but sicker patients into home health services.

This brings me to my second point. Home health is local and in our service area that means rural. The loss of the rural add on and the changes in wage index has significantly impacted rural agencies throughout the country. In our agency the ramification of rural add on loss and wage index changes total over $1.2 million on a $9 million budget. We have had to pull out of several counties.

To my knowledge, no home health provider in these counties is able to provide the full compliment of Medicare home health services. Staff shortages are common in many agencies across the nation. We have been recruiting for a full time physical therapist for over 900 days.

MedPAC's financial analysis of Medicare home health agencies alleging a 16 percent margin is unreliable. It excludes the 21 percent of agencies that are part of a hospital or skilled nursing facility. When all agencies' margins are included and given equal weight the true average margin is 3.12 percent.

About one-third of home health agencies have Medicare margins at or below zero. Our overall margin is 4.9 percent but drops to 2.8 when United Way, grant and other charitable funds are removed. We have benefited from the generosity of local foundations and the receipt of two USDA grants. These grants allowed us to acquire over 150 tele-health units and other patient care technology.

The USDA grants, which require an agency match, total over $600,000. Even using technology to improve our productivity, our mileage expense is just under a half a million dollars this fiscal year but down $200,000 before technology. Yet technology such as tele-health is not included in the allowable costs on the Medicare cost report, nor does the tele-health monitoring event count as a home health visit.

As part of the proposed rule to refine the home health prospective payment system CMS added cuts in the base payment rate. This would come on top of the President's Budget proposal to eliminate the inflation adjustment. Over the past 10 years, the Medicare home health benefit has been cut nearly every year. Once comprising 8.7 percent of Medicare spending, today it is 3.2 percent and it's projected to drop to 2.6 by 2015.

Given our growing population of elderly and disabled, cuts to the home health benefit will only prove to be penny wise and pound foolish.

In conclusion, Mr. Chairman and Ranking Member Camp, we respectfully request that the Subcommittee request CMS to suspend its plan to cut home health payment rates based on unfounded allegations of case mix creep, not reduce the annual inflation update, expand access to technology and tele-health, reinstate the rural add on.

NAHC and MHHA look forward to working with the Subcommittee to address the home health payment adequacy issues as outlined in this testimony. This concludes my formal remarks and I'll be happy to accept any questions.

[The prepared statement of Ms. Chesny follows:]

Prepared Statement of Christine Chesny, on behalf of National Association for Home Care and Hospice and the Michigan Home Health Association

Thank you, Mr. Chairman, Ranking Member Camp, and Subcommittee Members, for inviting me to present testimony on issues related to payment accuracy and legislative and regulatory payment refinements for the Medicare home health prospective payment system. My name is Christine Chesny. I am President of MidMichigan Visiting Nurse Association (VNA), a not-for-profit affiliate of MidMichigan Health, the largest health care system in north-central Michigan. MidMichigan Visiting Nurse Association provides home health, hospice, home medical equipment, palliative care and private duty nursing services to eleven rural counties in the heart of Michigan. As a part of the MidMichigan Health family of services, we support a continuum of care that includes: 4 acute care hospitals with 481 beds, a critical access hospital, a 200 bed skilled nursing facility and 40 assisted living beds, an urgent care center with mobile diagnostics, such as PET scanning, and over 300 physicians and mid-level providers on staff. I am also the immediate Past President of the Board of Directors of the Michigan Home Health Association (MHHA), and a finance committee member of the National Association for Home Care and Hospice (NAHC).

NAHC is the largest home health trade association in the nation. Among our members are all types and sizes of Medicare-participating care providers, including nonprofit agencies such as the VNAs, for-profit chains, public and hospital-based agencies and free-standing agencies.

Earlier this year, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress eliminate the home health market basket update for calendar year 2008. Relying in part on MedPAC's recommendation the President's fiscal year 2008 budget proposes a reduction of nearly $10 billion in home health spending by imposing a five-year freeze in home health payments (2008 through 2012), and permanent market basket reductions annually thereafter of .65 percent. Additionally, the Administration also plans to reduce home health payments through regulatory changes by nearly $7 billion over the same five years. Home care, with its annual Medicare expenditures of only $13 billion, cannot sustain such draconian cuts without the loss of access to care throughout the country.

Preservation of the Medicare Home Health Market Basket Inflation Update is Needed to Protect and Preserve Care for Medicare Beneficiaries

MedPAC's rationale for freezing home health payments fails to address the true financial status of home health agencies. The recommendation is based on an incomplete analysis of Medicare cost report data that excludes a significant segment of home health agencies, ignores essential home care service costs, and relies on a methodology that treats home health services as if it were provided by one agency in just one geographic area. If enacted the MedPAC recommendation will severely compromise continued access to care.

In specific response to the recommendation, we note the following:

- The current Medicare home health prospective payment system (HHPPS) has been found to be seriously flawed and extremely ineffective at predicting the costs of care delivery. As a result, care for some types of patients can be reimbursed at significantly higher rates than agencies' costs while Medicare reimbursement for other patients is woefully inadequate. MedPAC has found that the payment distribution system of HHPPS fails in over 75% of the case cat-

egories to fairly set rates in relation to the level of care. Payment is either significantly lower or greater than justified for the level of care. These and other findings have led Medicare to undertake a wholesale revision of HHPPS that is scheduled to take effect on January 1, 2008.

- The considerable shortcomings in the HHPPS are further illustrated by a dramatic range in profits and losses among home health agencies (HHAs). About 31% of all HHAs experienced financial losses under Medicare in 2002; that figure increased to 33% in 2004. A five-year freeze would increase the number of agencies with Medicare margins of zero or below to around 60%. These figures actually understate losses because Medicare cost report data excludes the costs of numerous items that are legitimate care expenses, such as telehealth services and respiratory therapy.
- MedPAC's financial analysis of Medicare home health agencies, alleging a 16% margin, is unreliable. First, it does not include any consideration of the 1,723 agencies (21%) that are part of a hospital or skilled nursing facility. In some states, hospital-based HHAs make up the majority of the providers (MT 63.2%; ND 65.4%; SD 60.5%; OR 58.3%). These HHAs have an average Medicare profit margin of negative 5.3%. Second, the MedPAC analysis uses a weighted average, combining all HHAs into a single unit, rather than recognizing the individual existence and local nature of each provider. When all agencies' margins are included and given equal weight, the true average margin is 3.12%. MedPAC fails to evaluate the impact on care access that occurs with the current wide ranging financial outcomes of HHAs. Instead, it sees a single national profit margin as representative of over 8,000 very diverse HHAs.

Our overall profit in home health at MidMichigan Visiting Nurse Association is just under 5%. This number drops to below 3 percent when United Way, grant and other charitable funds are removed. We consider ourselves fortunate. Let me explain. As a non-profit free standing agency we receive charitable donations to support under and uninsured patient care including Medicaid. We also benefited from the generosity of local foundations as our agency first implemented laptop computers for clinicians in 1998. Since that time we have been even more fortunate to receive two USDA grants. These grants allowed us to acquire over 150 telehealth units, pulse based oxygen concentration meters, blood clotting time meters, and more computers for both branch offices and clinical staff. The USDA grants, which require an agency match total over $600,000. No small investment for any home health agency.

The use of technology has enabled our agency to more efficiently and effectively care for our patients while maintaining high quality outcomes. For other agencies unable to make this capital intensive investment, the economies are lost and their costs continue to rise. Even using technology to improve our productivity, our average miles per visit is 22 which translates into an expense of just under a half million dollars this fiscal year. Yet, CMS does not recognize telehomecare technology equipment and patient service costs as reimbursable by the Medicare program.

This brings me to my second point. Home health care services are local. And in our service area that means rural. The loss of the rural add-on and the changes in wage index have had significant impact on our agency and other rural agencies in Michigan and throughout the country. The wage index calculation is fundamentally flawed as rural hospitals are continuously reclassified to CBSAs eliminating their costs from the rural calculation. In our agency, the ramifications of the loss of the home health rural add-on and wage index change total over $1.2 million on a $9 million budget. We have had to make difficult decisions regarding our service area. We eliminated our two most northern counties 3 years ago. We also eliminated the majority of another county whose population is only 17,000 residents and are contemplating reducing the service area in the northern most reaches of two other counties. The void will not be easily filled. To my knowledge, no one in these areas is able to consistently offer the entire Medicare covered services in the home health benefit. Our agency is unable to afford the price that physical therapists demand for work in these areas. We have been persistently recruiting for a full time physical therapist for over 900 days.

- With the existing HHPPS, an agency's mix of patients (case-mix) can result in significant profits or losses unrelated to efficiency or effectiveness of care. Losses exist for agencies of all sizes and in all geographic locations that are a result of the flawed HHPPS. These agencies are essential care providers in their communities. An across-the-board cut or freeze would do tremendous financial damage to those agencies that are at break-even or losing money on Medicare.

- Home health agencies are already in financial jeopardy as a result of Medicaid cuts and inadequate Medicare Advantage and private payment rates. Ongoing study of home health cost reports by the National Association for Home Care & Hospice indicates that the overall financial strength of Medicare home health agencies is weak, and expected to diminish further. In 2002, the average all-payor profit margin for freestanding HHAs was 2.53%. A more recent cost report data analysis indicates that the average all-payor profit margin for 2004 dropped to 1.55%.
- Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the HHPPS.
- A loss of the market basket inflation update could leave home health providers no alternative but to cut down on the number of visits per episode or avoid certain high-cost patients altogether, which could have potential adverse consequences on care access and patients' clinical outcomes. It would be difficult for HHAs to continue to lower visit frequency without compromising quality of care. Outcome Concept Systems, a national home health benchmarking firm, has found, in general, that reductions in average visits below 20 visits per episode (the current average is around 18) result in lower outcome scores.
- Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, with better patient outcomes.
- Home health agencies have already experienced a disproportionate amount of cuts in reimbursement as a result of the Balanced Budget Act of 1997 (BBA). For example, under the BBA, Congress expected to reduce Medicare home health care outlays in FY 2006 from a projected $40.4 billion to $33.1 billion. The Congressional Budget Office (CBO) now estimates that home health outlays for FY 2006 were $13.1 billion. This reduction is far in excess of the reduction originally envisioned by Congress, and already has had a profound impact on beneficiary access to care and HHA financial viability. Home health care as a share of Medicare spending has dropped from 8.7 percent in 1997 to 3.2 percent today. By 2015 it is projected to drop to 2.6 percent of total Medicare spending.
- Over the past 10 years, the Medicare home health benefit has been cut nearly every year, placing serious financial strains on HHAs:

FY 1998–1999	Home health interim payment system (IPS) was implemented. During two years under IPS Medicare spending for home health care dropped from $17.5 billion to $9.7 billion and the number of Medicare beneficiaries receiving home health services dropped by 1 million. Over 3,000 home health agencies closed their doors.
FY 2000	Home health care's inflation update was cut by 1.1%.
FY 2002	Home health care's inflation update was cut by 1.1%.
FY 2003	Total home health care expenditures were cut by 5% off previous year's rates.
CY 2004 (3/4 of year)	Home health care's inflation update was cut by 0.8%.
CY 2005	Home health care's inflation update was cut by 0.8%.
CY 2006	Home health care's inflation update of 3.3% was eliminated.

CMS' Proposed Revisions for the Home Health Prospective Payment System

As discussed earlier, all indications are that Medicare's current payment system for home health is flawed, and that, rather than across-the-board cuts that will

harm those agencies that can least afford it, a redistribution of payments through refinements in the home health prospective payment system is the appropriate course of action. Medicare recently proposed major changes in the payment system to institute a more balanced reimbursement method to take effect in 2008. NAHC has strongly supported CMS efforts to restructure the system and to replace a poorly functioning case mix adjustment model that determines the payment rates for 80 different patient categories. However, as part of the proposed rule, Medicare added the administrative cuts proposed by the President in his 2008 budget, thereby jeopardizing the intended benefits of the reforms.

The intended purpose of the payment system changes was to refine the case mix adjustment so that the payments would be more fairly distributed. Instead, CMS put forward a blatant effort to extract over $7 billion from the system. Specifically the proposal would cut payment rates by 2.75% for each of the next three years (beginning in 2008). This cut will spell disaster for access to services.

The proposal indicates that the cuts are intended to eliminate the effect of increases in patient coding that does not reflect changes in the patients' characteristics. CMS assumes that, because the average case mix weight of home health patients has risen since the first year of the PPS (from approximately 1.135 to 1.233), every single point of that increase has been due to provider "gaming" of the system, or deliberately establishing a higher case mix weight to secure higher reimbursement under Medicare. CMS refuses to acknowledge that the patients under the care of home health agencies have dramatically changed since the inception of PPS in October 2000. Instead, CMS concludes that there has been absolutely no change at all.

I think that it is important for those of you unfamiliar with the payment system to understand what this assumption of gaming means. Home health patients are not simply taken onto service and "assigned" a case-mix weight by the home health agency. Instead, a physician orders specific care based on the patient's condition and neee0257ice ah agenyr accpnts n patient for servict, a rgiastesednourse er thrapias -

ceiving the supportive personal care of home health aides for an extended period of time, physical and occupational therapy have taken on a greater role, leading to improvements in function and self-sufficiency. The average length of stay in home health services has dropped to less than 90 days from a pre-PPS average of over 150 days. Correspondingly, therapy visits have increased by over 25% to an average of five in a 60-day episode. This change was part of the congressional purpose behind the mandate to create the PPS. That change has benefited the patients and Medicare in that home health expenditures remain far below 1997 levels of $17 billion.

2. Patients are discharged into home health services from inpatient hospitals earlier than ever before. This is evidenced by the institution of the hospital transfer DRG policy. Under that policy hospital payments have been reduced in multiple DRGs because the transfer of patients from hospitals into home health has reduced the inpatient length of stay. Those discharges have led to the admission of patients into home health with higher acuity levels than ever before.
3. The alteration of coverage and payment standards at Inpatient Rehabilitation Facilities (IRF) and Long Term Care Hospitals (LTCH) has increased the number of rehabilitation patients in home health as well as their level of service needs. For example, the phasing in of the 75% rule for IRFs has steered more patients with higher needs for therapy appropriately into home health services.

CMS has failed to utilize a sound methodology to determine the extent to which the increase in case mix weight is due to changes in patients or changes in coding. In its published analysis, for example, CMS admits that more patients are admitted into home health care from Skilled Nursing Facilities (SNF). This is a factor that the CMS scoring system considers as a strong indication of patients with greater care needs, yet CMS ignores this fact in reaching its conclusion that all the increase in case mix weight is "coding creep."

More alarming is the fact that CMS considers the increase in therapy services to be unrelated to any change in the nature of patients served. Effectively, this conclusion means that CMS considers the therapy visits to be unnecessary all across the country without ever reviewing actual patient care records. This conclusion flies in the face of the significant rehabilitative gains of the home health patients and the numerous structural changes in other care settings that impact on the patient population served by home health agencies.

Instead, the primary justification that CMS offers for its conclusion is that home health agencies have received policy clarifications and training on how to complete the patient assessment forms. That justification is a strong indication that CMS is desperately grabbing onto anything available to explain its action.

In 1997 with the Balanced Budget Act, Congress set in motion a revolution in the Medicare home health benefit. With changes to both the payment system and the scope of the benefit coverage, Congress shifted home health services into a rehabilitative oriented benefit with strong controls on expenditures. Those goals have been accomplished yet CMS, through its unfounded and unprecedented conclusion that patients have not changed since 2000, now seeks to undermine this remarkable Congressional success by instituting an 8.7% cut in payment rates through 2.75% reductions in each of the next three years. That proposal can only serve to derail the gains over the last seven years. I urge Congress to intervene and stop CMS before damage is done to Medicare beneficiaries.

CMS Should Not Undermine Its Worthwhile Effort To Refine the Home Health Prospective Payment System By Making Rate Cuts

In its proposal to reform and refine the Medicare home health PPS, CMS offers many improvements that will likely redistribute payments in an improved manner. NAHC and MHHA have long supported efforts to correct weaknesses in the PPS model. However, the additional proposal by CMS to reduce the base payment rate to account for increases in the average case mix weight will jeopardize the effectiveness of the proposed corrections. The indications of that threat are:

1. The "case mix creep" adjustment is applied to all home health agencies whether they engaged in abusive coding or not. In fact, any offending agencies are better positioned to absorb the impact of the cut than those agencies that did everything above board. This approach makes the many pay for the sins of the few (if any exist).
2. The increase in case mix weight is primarily due to an increase in therapy services to patients. To the extent that the current system encourages inappropriate increases in those services, the CMS reform proposal institutes a

corrective course. Under the current system, higher payments occur whenever patients receive 10 or more therapy visits in a 60 day episode. The proposal replaces the 10 visit threshold with a system that changes payment rates at 6, 14, and 20 visits, with additional incremental changes between those points. This modification is intended to align payment more closely to patient needs. However, combining this change with the coding adjustment reduction is in effect a "double dipping" in that payment rates for patients with 10 or fewer therapy visits are greatly reduced through both the cut and the payment system reform.

3. The case mix weight adjustment is not the only step taken by CMS to reduce agency payment rates. To achieve budget neutrality with the system reforms CMS institutes an additional adjustment to the case mix weights. This adjustment reduces payments by approximately 4% based on an apparent assumption that providers of services will modify their care behavior to increase Medicare expenditures. The CMS proposal is devoid of transparency in that there is no explanation as to how this adjustment is calculated.
4. The true impact of the PPS reforms will not be known until some time after their implementation. The 8.7% payment rate reduction over three years through the case mix weight adjustment seriously complicates any ability to determine whether care and access change that may occur is due to weakness in the new payment model or errors in calculating the case mix weight adjustment. With the serious errors that we believe exist in that adjustment, the goals of the reform will not be realized.

The combination of these factors serves to destabilize the home health benefit at a time when it is intended to achieve greater accuracy in payment rates. In the midst of this chaos are the Medicare beneficiaries and the uncertain future for access to care in their homes.

Conclusion

Home health services are part of the solution to growing health care expenditures in Medicare. Increasingly, home health services are a less costly alternative to inpatient services and institutional care. Home care also has a long history of exceptional care quality. Invariably, our patients express high marks for home care services. Now is the time to support and expand access to home health services under Medicare and all federal health programs to address a growing population of elderly and disabled. Cuts to the home health benefit will only serve to prove that it is "penny wise and pound foolish." We need to look no further than to the increased expenditures for Inpatient Rehabilitation Facilities, Long Term Care Hospitals, and Skilled Nursing Facilities following on the heels of the massive home health services cuts in the Balanced Budget Act.

We respectfully recommend that the Committee:

1. Request that CMS suspend its plan to cut home health payment rates based on unfounded allegations of unwarranted increases in patient case mix weights as set out in its April 26, 2007 proposed rule.
2. Withhold any reductions in the annual inflation update for home health until the impact of the implementation of the prospective payment system in 2008. This step is particularly essential with the pending $7 billion in cuts in the CMS regulatory proposal.
3. Expand access to technology and telehealth services in home health services through grants, loans, and elimination of restrictions on the use of telehealth within the Medicare benefit.
4. Reinstate the rural add-on to preserve services in our nation's rural communities.

NAHC and MHHA look forward to working with the Subcommittee to address the home health payment adequacy issues as outlined in this testimony. This concludes my formal remarks. I would be happy to answer any questions from the Subcommittee members.

Chairman STARK. Thank you very much.

Dr. Walsh, would you like to enlighten us, please?

STATEMENT OF MARY BETH WALSH, M.D., AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Dr. WALSH. Thank you, Chairman Stark, Ranking Member Camp and Members of the Subcommittee. I appreciate the opportunity to testify today on behalf of the American Medical Rehabilitation Providers Association, representing more than half of the some 38,000 inpatient rehabilitation beds in the United States.

Could I ask that my written testimony be made part of the record in light of members' time?

We are sensitive to the difficult budget pressures and choices facing this Committee and this Congress under the Pay-Go budget rule, but we have to urge you to use this constraint to balance provider payment needs more fairly, much of which you've heard through this whole panel today.

Medical rehabilitation is that piece of medicine that is dedicated to providing patients everything they need to recover from debilitating illness and injury to achieve maximal functional independence and hopefully return to home and community living.

The existence of this critical sector of health care is threatened by some current in-process Medicare policies just at the time, as you have heard, we are all Baby Boomers aging up, and our wounded soldiers are returning home and moving out of acute care into our fragmented post-acute care world.

I should introduce myself. I am a rheumatologist, which is an internist specializing in the care of arthritis and other rheumatic diseases. I also direct Burke Rehabilitation Hospital, which is a 150 bed, freestanding rehabilitation hospital in New York, a Cornell University academic affiliate since the 1930s, and I've been trying to do this since 1979.

We are testifying today seeking legislative relief to address the two critically important issues impacting this field. The first is the 75 percent rule and the second is the unprecedented increase in claims denials experienced by providers across the country of rehabilitation services.

First let me hit the 75 percent rule. When CMS revised it in 2004 it failed to use that opportunity to update these criteria in accordance with the 25 to 30 years of medical practice. Patients with certain cardiac disease, with crippling pulmonary disease, with cancers, with organ transplants living in ways that were not imagined 30 years ago have come in need of this level of service in order to walk out of the hospital. So, the rule does not represent these changes.

You have heard from several of the earlier panel that there is no access problem. Well, from where I sit there is an access problem. Let me describe to you a 72-year-old gentleman with a lymphoma who 25 years ago in this rule there was no treatment for so he certainly would not have survived. After a long and arduous course in an acute care hospital, on and off a ventilator with various chemotherapy and lung surgery he did survive.

He is not one of the diagnostic criteria that one could count, so if he presents to our hospital for an absolutely medically necessary level of care, first we have to decide are we close to the percent rule. If it's early in the year we can take him because hopefully we're not. If we've been careless and we're a little over it, we will

have to deny him access in order to continue to provide care to any patients. This is an access problem.

CMS has underestimated the impact. In the final rule it estimated a .1 percent drop in the number of patients treated. MedPAC noted that in the first year that was 9 percent. MedPAC anticipates that rehab hospital patients will drop an additional 20 percent as we move to the 65 percent rule, and you have heard that this is some 80,000 plus patients.

The financial impact of the rule has also considerably exceeded the estimates. In the first year alone it was approximately $343 million not the much lower estimate.

I think the critical question here, separate from numbers and dollars, is so what, which lets me talk for a second about the quality of care provided in inpatient rehab hospitals and units. There is a longstanding tradition in this field to measure our individual patient outcomes, how long are they in the hospital, do they go home walking or in need still of my distinguished colleague's home care services or are they independent enough to go to an outpatient program? How many days did that take? How many of them got sick enough to go back to an acute care hospital? These are reported. These are measured. These are quality measures that matter to a patient. It's their quality outcome, not the state of other things.

There is a growing body of published research that indicates that in non-hospital based settings, although the per day cost may and is lower, the length of stay may be approximately twice, the number of patients needing rehospitalization because they're not in a hospital with 24-hour nurses in physicians there may well be about twice. This all costs money as well as poor patient outcome and suffering.

MedPAC, in its 2007 report to Congress, noted that there was a decline in one of these areas, the skilled nursing facility 30-day community discharge had declined consistent with what I indicated. I would ask that before an entire infrastructure and this field of medicine is dismantled completely the government should be required to demonstrate that its policy changes are indeed in the best interests of the patients that we serve.

Because my time, I see, has run out I will just in two sentences tell you that the second area is the fiscal intermediary denial made under local coverage decisions, which I think some of you are aware of in your own districts. These denials do not reference or improperly apply the more than 20 year rules of coverage, so we are asking you to codify in statute the coverage rules contained in ruling 85 to bring some uniformity across the country to this field.

So, in summary, I testified because we are urging you to support the enactment of H.R. 1459. The field is prepared to work with Congress, with CMS, with all of our other sectors of the acute and post-acute care world to define an appropriate continuum of care that should be used to guide patient placement and Medicare coverage decisions, which will eventually reduce the true cost to the Medicare Program by providing the right care in the right place.

Thank you for your patience as I went over, and I'd be happy to answer any questions.

[The prepared statement of Dr. Walsh follows:]

Prepared Statement of Mary Beth Walsh, M.D., on behalf of American Medical Rehabilitation Providers Association

Chairman Stark, Ranking Member Camp, and Members of the Subcommittee on Health, I appreciate the opportunity to testify on behalf of the American Medical Rehabilitation Providers Association (AMRPA) concerning payment systems for fee-for-service providers. The American Medical Rehabilitation Providers Association (AMRPA) is the leading national trade association representing over 550 free-standing rehabilitation hospitals, rehabilitation units of acute care general hospitals, and numerous outpatient rehabilitation services providers. Our members serve over 450,000 Medicare and non-Medicare patients per year, and most, if not all, of our members are Medicare providers. They also represent over half of the 38,388 inpatient rehabilitation hospital and unit beds in the country.

Let me say at the outset, AMRPA is sensitive to the extremely difficult budget pressures and choices facing this Committee and this Congress under the "pay-go" budget rules, but we urge you to use this constraint to balance provider payment needs more fairly. For example, the financial benefits provided to Medicare Advantage plans have come at the expense of other providers and deplete the Part A Medicare Trust Fund; these inequities should be addressed as the Medicare Payment Advisory Commission (MedPAC) suggests, and as the Committee, assesses how to proceed. However, it is our hope that the challenges of this cost-containment environment will recognize the vital role that rehabilitation hospitals and units play in providing care and services aimed at placing patients back into their homes and communities where they can resume their independence.

Mr. Chairman, AMRPA testifies before you today seeking legislative relief that would address two critically important issues that are adversely impacting inpatient rehabilitation providers and patients who need their services: (1) the 75% Rule; and (2) an increasingly aggressive pattern of medical necessity-based denials against claims filed by inpatient rehabilitation hospitals and units, the frequency of which is unprecedented in comparison to any other Medicare Part A provider segment. AMRPA is vitally concerned about both of these issues, as they are increasingly eroding access to high-quality rehabilitation care for those who need it.

With respect to the 75% Rule, we recognize the propensity of this Committee to defer to the Centers for Medicaid and Medicare Services (CMS) in the regulatory rulemaking arena. It is critically important to note, though, that the 75% Rule is no longer a regulation falling solely within the jurisdiction of CMS. As part of the deficit reduction legislation enacted into law early last year, Congress asserted jurisdiction over the 75% Rule and temporarily maintained it as its current level, 60%, for an additional year. Unless Congress takes timely action this year, the Rule will remain on its current trajectory toward escalating to the 65% and then 75% threshold levels. Even if CMS wanted to alter the 75% Rule threshold percentages on their own, the agency could not do so given the statutory framework.

The situation I present to you today is perhaps most analogous to the overreaching that occurred after implementation of the Balanced Budget Act of 1997. In that instance, the Department and Congressional Budget Office (CBO) grossly miscalculated and underestimated the savings that would be achieved by the adoption of certain agency cuts. In the case of the inpatient rehabilitation hospital and unit (IRH/U) 75% Rule, here too the Department substantially underestimated the adverse Medicare beneficiary impact and the cost savings impact of its rulemaking. The 75% Rule threatens seniors by denying them access to the vital inpatient medical rehabilitation services provided by IRH/Us. Even in its most recent rulemaking promulgated just a few weeks ago, the Department continues to publish inaccurate data that significantly underestimates the beneficiary access implications and financial impact under the Rule.

Rehabilitation providers are dedicated to helping Medicare and Medicaid beneficiaries recover from debilitating conditions through medical rehabilitation. We are all aware that post-acute care will become more and more important as the population ages. As we prolong life, previously fatal diseases have become chronic conditions, and people want the opportunity to regain function and live in their homes and communities as independently as possible. At the same time, it is hard to ignore that our aging population, as well as our disabled veterans returning from combat, keenly need—and will continue to need indefinitely—access to high-quality medical rehabilitation care. The very existence of the critical inpatient rehabilitation sector of the health care arena is threatened by these Medicare policies which are the focus of my testimony today.

Impact of the 75% Rule

To participate in Medicare under the prospective payment system for inpatient rehabilitation facilities (IRFs), inpatient rehabilitation hospitals and units must satisfy the 75% Rule, in addition to other criteria. The Rule requires that a certain percentage of IRF patients fall within 13 diagnostic categories. Patients outside the 13 qualifying conditions are often denied IRH/U access.

Background on the 75% Rule

In 1983, when Congress passed the law mandating the use of diagnosis-related groups (DRGs) as the basis for payment of acute care hospitals, it excluded certain types of hospitals from that payment system, including rehabilitation hospitals and rehabilitation units of general acute care hospitals. However, the Secretary of the Department of Health and Human Services had to define these facilities in order to distinguish them from acute care hospitals and thereby exclude them from the DRG payment system. The Secretary published seven exclusion criteria that IRFs must meet in order to be paid separately. One of these criteria for provider participation in the Medicare program is known as the "75 Percent Rule" because it requires that 75% of Medicare *and* non-Medicare patients fall within a list of 10 conditions: stroke, spinal cord injury, brain injury, neurological disorders, burns, amputation, fracture of the femur, polyarthritis, major multiple trauma, and congenital deformity.

When CMS revised the 75% Rule in 2004, it redefined the list of 10 conditions in a way that excluded many cases long considered to fall within the 75% Rule. Herein lies the major compliance and enforcement problem, as CMS started counting and defining cases differently. In addition to a substantial narrowing of the universe of cases that could be deemed compliant with the Rule, other important diagnoses—such as cardiac, pulmonary, cancer, and transplant—were not added. There has been little discussion of the medical and/or scientific bases for the Rule's inclusion or exclusion of various clinical conditions or medical diagnoses. Furthermore, the revised 75% Rule allows certain patients who meet the definition of a "comorbidity" to be included in the compliance threshold. Yet when the Rule is fully implemented those same patients will no longer comply—a policy approach which is logically and medically inconsistent and is not supported by any medical or clinically-based evidence or data. The revised 75% Rule simply does not represent any changes in medical science or practice and their connections to the advancements made in the field of physical medicine and rehabilitation over the past quarter-century. It also does not recognize the decreased mortality rates for certain health care conditions and how those cases can be improved by intensive rehabilitative care.

Impact of the 75% Rule

CMS' policy and savings objectives clearly have been achieved and continue to be achieved. The 75% Rule impact on patient access has been significant, even after implementation at only the 60% compliance threshold. Access is most restrictive for patients whose medical rehabilitation care benefits from newer rehabilitation specialties such as cardiac, pulmonary, pain, and cancer care. As a result, the number of Medicare cases treated in IRFs declined by 88,000 patients during the first two years of 75% Rule phase-in, some rehabilitation hospitals and units have closed, and many providers have significantly reduced beds, services, and staff. All of this confuses patients, physicians, and general acute-care hospitals. It also forces rehabilitation hospitals and units into an arbitrary, quota-based lottery system for their services, depending on whether they are "meeting their number"—meaning the same patient could be admitted at the beginning of the month but not admitted toward the end of the month, regardless of physician judgment and medical necessity.

CMS Underestimated the Impact of the 75% Rule in Terms of the Patients Who Are Prevented from Accessing Care in Inpatient Rehabilitation Hospitals and Units

Due to the revisions made to the 75% Rule, a large number of patients with medical conditions and diagnoses that previously satisfied the Rule are unable to access the care and services of inpatient rehabilitation hospitals and units. Multiple reports have shown that patient volume has fallen at a rate much greater than anticipated by CMS when adopting the 75% Rule. In the Final Rule of May 7, 2004, CMS indicated that it anticipated a 0.1% drop in the number of patients treated in IRFs during the first full year of implementation of the Rule. This number has been shown through multiple analyses to be grossly understated in terms of the devastating impact implementation of the Rule has had on inpatient rehabilitation hospitals and units. There has been a dramatic drop in total volume, by specific types of cases, as well as a number of unintended consequences of the Rule.

In 2006 and 2007, the Medicare Payment Advisory Commission (MedPAC) examined the payment adequacy of the IRF PPS. In both years, MedPAC examined closely the impact of the 75% Rule on the margins and operation of IRFs. It noted in 2006 that the volume of patients dropped by 9% from 2004 to 2005 due to implementation of the Rule. In its 2007 report, MedPAC anticipates that patient volume in IRFs will drop an additional 20% as facilities come into compliance with the 65% compliance threshold slated to take effect on July 1, 2007. The Commission also noted in its March 2007 report that only 449,321 cases were treated in IRFs in 2005, compared to 496,695 cases treated in 2004.

The inpatient medical rehabilitation field has independently analyzed the total volume drops since the inception of the Rule and also found that the total impact well exceeds the original estimates. Using data supplied by the field, the Moran Company has analyzed the impact of the 75% Rule and tracked the decline in caseload on a quarterly basis. The data reviewed originated from two large industry data bases, representing 75% of all Medicare IRF discharges. The Moran Company report through the second quarter of 2006 notes that the total Medicare case load declined by 88,053 cases over the first two program years of the Rule. It also notes that for program year 2006, the Medicare case load was down 12.4% from Program Year 2005 and 18.4% from Program Year 2004.

In a separate analysis, AMRPA/eRehabData® noted a decrease in Medicare patients for the first year of 34,624 and of non Medicare patients of 5,970 compared to the year before the implementation of the Rule and a decrease of over 85,282 Medicare patients and 9,428 non-Medicare patients in the second year of the Rule compared to the year before implementation of the Rule. In the third year of the Rule, which is almost completed, AMRPA anticipates that even though the threshold has been held at 60% for a second year, the number of people denied care will increase to 118,281 Medicare patients in anticipation of moving to the 65% level as compared to the level of cases in the year prior to the Rule's implementation.

Unless legislative relief is provided, Congress should expect even more caseload decline as implementation of the 75% Rule continues. eRehabData® estimates that once the compliance threshold moves to 65%, the number of Medicare patients not served will increase to 138,344 compared to the year before the Rule was implemented. This represents a decrease in volume of 29.57%, which supports MedPAC's estimates.

The Rule's Intended and Unintended Consequences on Patient Access

As noted above, the medical rehabilitation field has also found that certain types of cases are no longer receiving care in inpatient rehabilitation hospitals and units. The Moran Company has been tracking the change in the types of cases denied care. In its Q1 2007 report "Utilization Trends in Inpatient Rehabilitation: Update Through Q1:2007," it notes that the "five categories with the largest declines account for nearly 90% of the total decline in caseload in the first quarter of 2007, relative to the first quarter of 2004." These five categories are as follows: (1) replacement of lower extremity joints, (2) miscellaneous cases which includes all cancer cases, (3) cardiac, (4) pulmonary, and (5) other orthopedic cases. Of great interest, however, is that since the second quarter of 2006, there has been a decrease in the number of stroke cases served.

AMRPA has tracked the changes in the volume of cases by type. We note also that the changes from the first quarter of 2004 to the first quarter of 2007 show that the largest drops are in the categories of osteoarthritis (−79.32%), pulmonary (−57.68%), amputation, other (−58.49%), pain (−50.82%), replacement of lower extremity joint (−49.51%), and rheumatoid, other arthritis (−49.66%). As with the Moran data, there is also a drop, albeit smaller, in treatment of stroke patients. Additional AMRPA analysis of Impairment Group Codes (IGCs) found a number of additional changes in access which are quite disturbing. Stroke cases, brain injuries, cerebral palsy, burns, specific types of paraplegia and quadriplegia, and other complex cases are being treated less and less frequently in the inpatient rehabilitation setting.

Where patients who are denied admission to inpatient rehabilitation hospitals and units go to receive services is not clear. Of greater concern are the outcomes of their care in terms of the key hallmarks of rehabilitation. These include length of stay, mortality, infection, complication rates (e.g. DVT, pneumonia, other), readmission to acute care, and primary motor and cognitive function.

Of grave concern is the decline in both the number of traditional comprehensive medical rehabilitation cases and the number of patients with newer conditions that benefit from medical rehabilitative care. CMS's changes in 2004 essentially eliminated most arthritis and single joint replacements from being served in IRH/Us. There is also a drop in the areas where medical science is making great advance-

ments in mortality and longevity, turning serious cardiac, respiratory and especially cancer diagnoses into conditions to be managed (frequently after surgery), not death sentences. Even before the IRF PPS was enacted, the medical rehabilitation field saw an increase in cardiac, pulmonary and cancer patients. Cardiac cases increased from 2.47% of cases in 1994 to 5.71% of cases in 2002; pulmonary from 1.98% is 1994 to 2.71% in 2002 and the miscellaneous category, which includes cancers and other serious pulmonary cases, from 5.43% in 1994 to 11.21 % in 2002. We believe this growth reflects underlying improvements in medical science, decreases in mortality, and therefore increased need and benefit from medical rehabilitation.

By 2006, cardiac cases had dropped to 4.17%, pulmonary to 1.53% and miscellaneous to 9.44% of the total cases. These cases are complex, resource-intensive cases and reflect the underlying shift in successful acute medical treatment and the then subsequent need for intensive hospital rehabilitation services. We do not believe that this effect was necessarily intended and that it may be of concern to hospital providers, patients with these conditions, their families, advocates on their behalf, and policy makers.

CMS Significantly Underestimated the Rule's Financial Impact

AMRPA has also tracked the financial impact of the Rule and again, it considerably exceeds CMS' original estimates. According to CMS' 2006 data, total Medicare spending amounted to $408 billion dollars, of which $6 billion is attributable to inpatient rehabilitation hospital services; therefore, inpatient rehabilitation spending represents only 1.5% total Medicare spending. CMS estimated that the total savings for IRF payments in the first year would be $5.4 million. When CMS accounted for care in other settings it estimated total net savings of $2.4 million. Using the eRehabData® database, we estimate that the drop in payments to IRFs in the first year of the Rule for Medicare patients alone was approximately $343 million and for non-Medicare patients a decrease of $59.2 million as compared with payments in the year prior to implementation of the Rule. In the upcoming fourth year of the Rule when the compliance threshold moves to 65%, we project that the drop in Medicare payments alone to IRFs will be $1.372 billion as compared to the year prior to the Rule; at 75% it will be $1.8 billion compared to payments in the year prior to the Rule's implementation. Given the size of this sector, this staggering decrease results in disproportionate financial consequences.

Congress and the agency must appreciate and recognize that the continued drops in patients, the increases in costs that cannot be otherwise covered by payments and the overall drop in payments cannot be sustained by the IRH/U field for an indefinite period. The Government has vastly underestimated the impact of this Rule at every turn—drop in total volume, impact on unintended populations, failure to recognize the growing types of patients that clearly need inpatient hospital and unit rehabilitation services and financial devastation by several orders of magnitude, unless the true intent of the Rule is to eliminate the inpatient rehabilitation hospitals and units as providers under Medicare.

CMS Should Retain Comorbidities for Purposes of the Exclusion Criteria in order to Ensure Access for Patients who Need Specialized Care

AMRPA urges enactment of the statutory protection provided by the legislative provision in the Tanner-Lowey-Hulshof-LoBiondo bill which provides for permanent retention of the use of comorbidities. AMRPA believes that the use of the comorbidities that meet the definition outlined in 412 C.F.R. 412.23(b)(2) and as listed in Appendix A of Transmittal 938 should be retained indefinitely or permanently for determining compliance with the threshold percentage. Comorbidity considerations represent a significant component of patient access to medically necessary inpatient rehabilitation. Simply shifting percentages does not change the clinical characteristics of the patients being admitted to an IRH/U overnight. There are patients who have a comorbidity that falls into one of the 13 conditions and have a significant decline in their functional ability. These are usually severely compromised patients for whom appropriate treatment is not available in other settings. They have significant functional involvement by definition due to the comorbidity or other complication and generally constitute both medically and functionally complex patients. CMS estimates that 7% of cases come from comorbidities—so moving to a full threshold of 75% is actually moving to 82%.

CMS Should Modernize Inpatient Rehabilitation Criteria, Per Clear Congressional Instruction

The failure to modernize the 75% Rule in any meaningful way since 1985, in combination with the agency's regulatory and compliance activities, have resulted in policies which are dismantling the infrastructure of inpatient rehabilitative medicine in the United States today. What is astonishing is that the agency's policies

are completely without explicit Congressional authorization. In fact, Congress has repeatedly expressed contrary intent. Initially, Congress conveyed its opinion through letters to the Secretary signed by more than half of the House of Representatives and 82 Senators—to reverse the regulatory course and halt further implementation of the Rule until the issue could be studied and a different regulatory course pursued. The Department disregarded no less than three formal Congressional requests to halt implementation of the 75% Rule. In a year when there was no appropriate moving authorizing Committee legislation, the Appropriations Committees of both the House and Senate included Conference Committee report language directing the agency to develop an alternative to the 75% Rule and enlist the assistance of an independent expert panel convened under the auspices of the Institute of Medicine (*see* H.R. Rep. No. 108–401). Congress clearly recognized that statutory intervention was required and therefore in 2005, imposed a freeze on the compliance threshold at 60 percent. Quite candidly, we perceive most Members of Congress would have gone further than the one-year fix provided at that time. The statutory language provided then now compels additional Congressional action in 2007. It is time to put the 75% Rule controversy behind us.

Codification of Medical Necessity Standard is Essential to Protect Patients and Provide Stability

In addition to the 75% Rule, inpatient rehabilitation hospitals and units have endured an unprecedented level of medical necessity denials over the past two years. Numerous CMS contractors have denied coverage for services provided in inpatient rehabilitation hospitals and units to thousands of patients. These denials are frequently based on local coverage determinations (LCDs) or case-by-case rationales that fail to reference or properly apply the binding rules for coverage that have existed for the past 22 years.

In order to address this problem, AMRPA supports codification of HCFA Ruling 85–2 in the Medicare statute, as called for in H.R. 1459. This ruling, which CMS issued in 1985, sets clear, clinically-based rules for inpatient rehabilitation coverage which have been used by HCFA and CMS over more than two decades to determine what constitutes medically necessary inpatient rehabilitative care. Because of the wording which gives primary deference to physician judgment, we believe this ruling is just as effective today as it was 22 years ago at establishing medical necessity for inpatient rehabilitation services. HCFA Ruling 85–2 established two basic requirements that must be met for inpatient hospital stays for rehabilitation care to be covered:

1. The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and
2. It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility, such as a skilled nursing facility (SNF), or on an outpatient basis.

The Ruling then sets forth eight criteria, which, if satisfied, demonstrate that both of these two requirements for inpatient rehabilitation are satisfied. These eight criteria stipulate that the patient must require:

1. Close medical supervision by a physician with specialized training or experience in rehabilitation;
2. Twenty-four hour rehabilitation nursing;
3. A relatively intense level of rehabilitation services;
4. A multi-disciplinary team approach to delivery of the program;
5. A coordinated program of care;
6. A significant practical improvement must be likely;
7. The rehabilitation goals must be realistic; and
8. The length of the rehabilitation program must be reasonable.

Over the past several years, Fiscal Intermediaries have issued a number of very restrictive local coverage determinations, also known as "LCDs," that deviate from HCFA Ruling 85–2 in significant and troubling ways. For instance, these LCDs sometimes require as a precondition to inpatient rehabilitation coverage that beneficiaries prove that their care could not be furnished in a skilled nursing facility—which is an impossible burden, requiring a detailed knowledge of the level of care provided across the SNF industry, which often varies considerably. Moreover, this is a completely subjective determination. Other LCDs create "rules of thumb" precluding coverage for certain patients, such as those who undergo joint replacements, with little or no regard to the individual beneficiary's comorbid conditions or medical history. We believe that these LCDs impermissibly supersede the patient-centered, clinically-based criteria of Ruling 85–2.

Fiscal intermediaries have used these LCDs to deny retrospectively thousands of claims, both through prepayment reviews and through post-payment audits. Even in the absence of LCDs, intermediaries are denying claims on questionable grounds similar to the LCDs just mentioned. Other Medicare contractors, such as Program Safeguard Contractors, are similarly denying claims across the board in a wholesale fashion.

These denials place a significant burden upon the rehabilitation hospitals and units affected, both in terms of the funds withheld and in the administrative burden of appealing the denials. AMRPA members have appealed many, if not all, of their denied cases. Our members tell us that they are winning the vast majority of their appeals in hearings before administrative law judges (ALJs). These ALJs, unlike earlier levels of review, are not contractors of CMS. The ALJs, therefore, function to provide independent third-party review. The high level of reversals of these claim denials demonstrates that Medicare reviewers are not adhering to the binding rules of coverage in Ruling 85–2. Providers and patients need the statutory protection from Congress for the current medical necessity standard.

This is why we urge Congress to codify in statute the coverage rules contained in Ruling 85–2 and make clear that LCDs are not to deviate from this federal standard. Ruling 85–2 sets straightforward, clinically-based criteria for evaluating medical necessity. It effectively safeguards the Medicare Trust Fund while also ensuring that Medicare beneficiaries receive the appropriate level of rehabilitation care to which they are entitled.

Recovery Audit Contractors are Compounding the Instability in the Field

AMRPA is also deeply concerned about how the Recovery Audit Contractor (RAC) process is unfairly amplifying the same misguided critical review and denials based on medical necessity with devastating consequences for the viability of providers in the states where RAC activity is occurring. Authorized as a demonstration project by the Medicare Modernization Act of 2003, RACs have been established in California, New York, and Florida, but will soon be expanded nationwide. RACs are charged with recovering overpayments and are paid a percentage of every dollar that they recover. The RAC demonstration is the first time the Medicare program has ever paid a contractor on a contingency basis for overpayment work or claims review. We believe that this payment scheme creates perverse incentives to deny as many claims as possible and place the burden on providers to appeal these denials.

AMRPA strongly supports efforts by CMS to identify and eliminate fraudulent and/or erroneous Medicare payments to maintain the integrity of the Medicare program. However, the RAC program appears to be more focused on collecting money regardless of the impact the audit activity has on hospitals and patients. The financial incentives in place for contractors have resulted in aggressive and inappropriate audit activity. Recovery audit contractors may retain a significant percentage of recovered payment, and contractors may be able to retain recovered payments even when CMS overturns the auditor's coverage decision. In addition, the appeals process is complicated and fraught with inherent barriers that deter providers from seeking appeals to RAC determinations. AMRPA thinks that the combination of financial incentives for contractors and perhaps insufficient oversight by CMS of RAC activities is wreaking havoc, adding instability to the field, and may be resulting in misapplication of Medicare policy.

A prime example of this problem can be seen in the State of California. The RAC in California, PRG–Schultz, has focused much of its energy on inpatient rehabilitation hospitals and units. AMRPA has heard reports from some providers that PRG–Schultz has denied virtually every claim it has reviewed. Single hospitals have had over 300 claims denied worth several million dollars. The denial letters that they receive from PRG–Schultz are usually form letters that repeat stock phrases that purport to explain the denials. It is clear, however, from the volume of denials, the time spent reviewing each case, and the pro forma nature of the explanations that this RAC is not conducting a meaningful medical review and applying the coverage criteria of Ruling 85–2. According to the California Hospital Association, these audits have resulted in significant financial hardship throughout the state's hospital system and may threaten access to rehabilitation services in California.

Quality of Care in Inpatient Rehabilitation Hospitals and Units

Inpatient rehabilitation hospitals and units provide high quality care to patients suffering from newer rehabilitation conditions, such as cardiac, cancer, transplants, pulmonary, and pain, as well as joint replacement patients who would also benefit from medical advancements. However, AMRPA remains concerned that patients are being turned away from quality inpatient rehabilitation care to settings less-suited to treat intense rehab needs. While there is a long-standing tradition in the rehab

field to measure quality and outcomes of individual patients, programs, and facilities, comparable efforts do not exist in SNFs, the setting in which most patients turned away from IRH/Us ultimately find treatment. In fact, as MedPAC and GAO have underscored to Congress, there are no systems in place in SNFs, Acute Care Hospitals, Home Health Agencies, or Long Term Acute Care Hospitals to determine rehabilitation necessity, program activity, patient benefits or need, or outcomes. Interestingly, while 78% of SNF admissions in the RUG system receive "rehabilitation," current SNF data collection does not include appropriate rehab or other outcome data. The SNF field has no way to collect such information, so we do not know what percentage of these patients ever become independent at home, at what cost, and over what period of time.

Notably, concern about the comparability of care in other health care settings has been articulated by not only rehabilitation providers, but also MedPAC and CMS. In its March 2007 Report to Congress, MedPAC noted that there was a decline in the quality of care for SNFs. At its April meeting, MedPAC further examined the issue of quality of care in SNFs. Dr. Andrew Kramer presented his study which examined the changes in factors associated with SNF rates of discharge to the community and rehospitalization between 2000 and 2004. He found that the rate of discharge to community is dropping and that rehospitalization rates are up, both of which he suggests reflect declining quality of care in SNFs. CMS is currently seeking to explore development of measures and systems for SNFs and all post-acute care, but it will take years to complete and make this new approach functional. However, despite the absence of measures, goals, standards for SNFs and LTCHs similar to IRF standards, and without a clinical evidence basis for action, CMS has doggedly moved forward with regulation and policy changes that have forced thousands of your constituents away from receiving their medically necessary care in a rehabilitation hospital or unit, and instead channeled them to SNFs and other settings.

What is perhaps most startling is the agency's dogged pursuit of the 75 percent policy absent any clinical data or outcomes analysis on the quality of care received, the overall costs to the health care system (including costs of rehospitalization, longer lengths of stay in other settings), and the impact on patient lives. The Department has no way of knowing what harm to patients has occurred since there is no evidence being accumulated.

An expanded national research effort is of paramount importance. AMRPA has been concerned since the inception of the 75% Rule that patients would not receive the same quality of care they receive in an inpatient rehabilitation hospital or unit. Therefore, in the past year, the field created the ARA Research Institute and has privately sponsored more than $2 million of research in an effort to understand and improve the quality of care, outcomes, and cost-effectiveness of the rehabilitation hospital compared to other settings, and to develop proper medical necessity standards. The newly formed ARA Research Institute has funded eight studies to date and, under sponsorship of other leading national associations, held a "State of the Science Symposium" in February 2007 to discuss the work in progress. We have shared abstracts with CMS, requested its comments and encouraged CMS to attend the Symposium.

My own hospital has participated in research to compare care between IRFs and SNFs. A study conducted at Burke Rehabilitation Hospital analyzed whether outcomes differed between patients with single knee or hip joint replacement surgery undergoing rehabilitation in an inpatient rehabilitation facility compared to a skilled nursing facility. Patients, matched for age, gender, operative diagnosis and admission ambulation function (FIM), who received rehabilitation in the IRH/U had, on average, a shorter length of stay and superior functional outcomes. The study is being repeated to include hip fracture patients as well, and to match for comorbidity, and measure actual dollars expended. The preliminary outcomes data shows that the clinical outcomes in subsequent study are similar to the results previously published. Patients treated in the rehabilitation hospital were less likely to require re-hospitalization, have shorter lengths of stay, and were more likely to be discharged home.

In the absence of governmental funding, the industry has taken steps to engage in the necessary research and modernize criteria for treatment. AMRPA and other leading organizations have produced an alternative model for defining medical rehabilitation hospitals and units, to demonstrate that the 75% Rule is not necessary to properly distinguish between rehabilitation and acute care hospitals. The American Academy of Physical Medicine & Rehabilitation (AAPM&R) has offered an approach that is perceived to be a better way of sorting patients into the proper setting. The field is convinced that it can work together with CMS and that patient-centered criteria for site of care can be developed.

Every day, AMRPA member hospitals hear clinical stories of frustrated and upset Medicare beneficiaries who are unable to receive the care they need and want because of these rules, and from angry physicians who cannot send their patients to the program they believe to be the best and most appropriate. SNFs play an important role in our health care system, but they are not a substitute for rehabilitation hospitals and units. Stated most simply, there is no evidence to support the Government and SNF industry's contention that care in other settings is of the same quality and less costly. Studies are now showing that the opposite is true. In general, for otherwise similar patients, those who are cared for in a rehabilitation hospital or unit make twice the progress, in less time compared to SNFs. Furthermore, given the increased length of stay in SNFs over IRH/Us, arguably Medicare payments to SNFs and IRFs are likely to be comparable, thereby bringing into questions CMS' claims of cost savings.

The Executive Branch to date has provided no evidence that its policy initiatives in this arena are clinically or evidence-based. Before an entire infrastructure and this field of medicine is dismantled completely, the Government should be required to demonstrate that its policy changes are in the best interests of (or at least will not harm) Medicare beneficiaries. In this instance, private sector patients are harmed as well in terms of access to medically necessary services. Moreover, the ultimate costs to the health care system are completely unclear. Aside from quality of life considerations, under the mantle of cost-savings, the agency policies may well result in higher long-term Government spending as patients receive care in other venues.

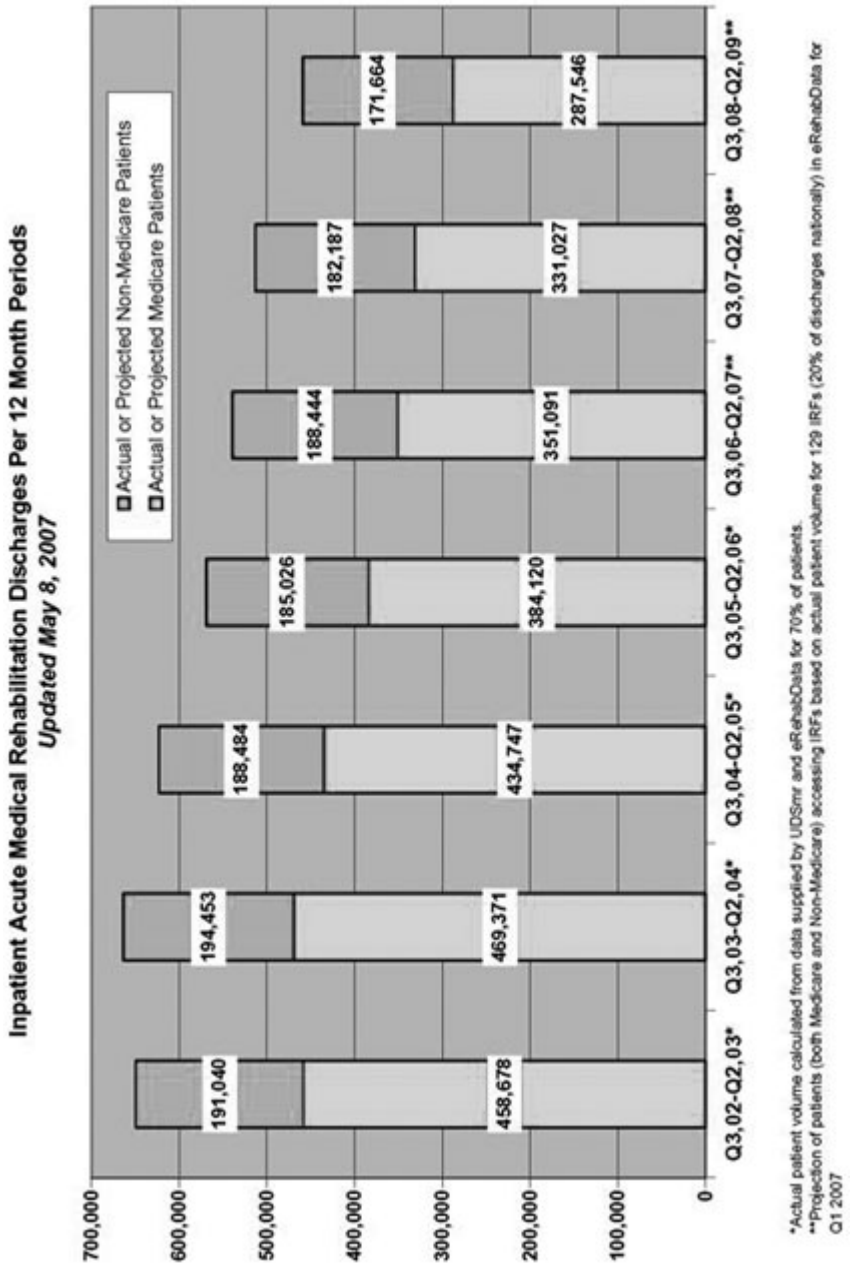
AMRPA Recommendations

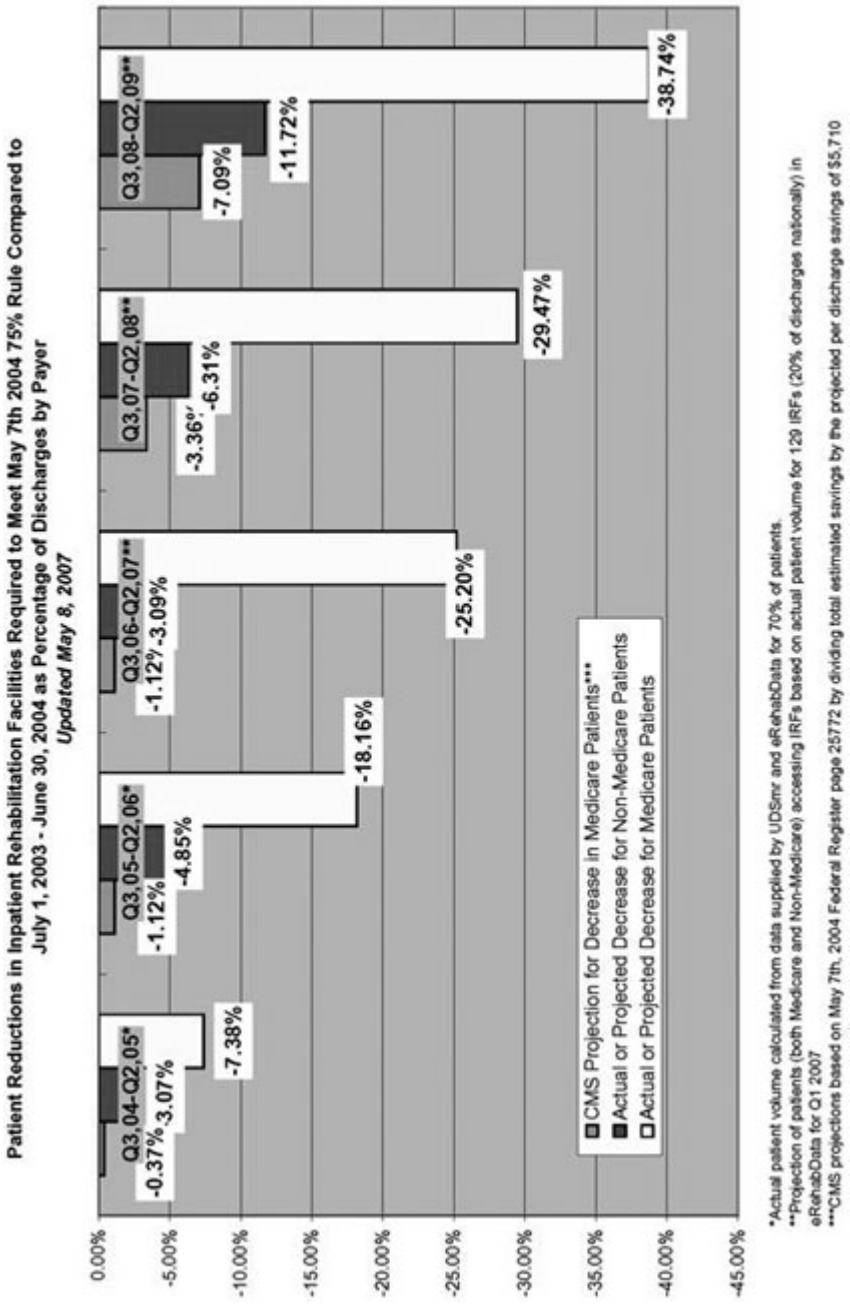
Mr. Chairman, I testify here today because the 60% compliance threshold legislative relief Congress provided (in Section 5005 of the DRA) expires for cost-reporting periods beginning on or after July 1, 2007. Recognizing the statutory problem in front of this Committee, Representatives John Tanner (D–TN), Nita Lowey (D–NY), Kenny Hulshof (R–MO), and Frank LoBiondo (R–NJ) introduced legislation that would freeze implementation of the 75% Rule as an immediate and short term fix to the current crisis. The Preserving Patient Access to Inpatient Rehabilitation Hospitals Act (H.R. 1459) presents a reasonable and balanced approach—the legislation extends the 60% compliance threshold, continues the use of comorbidities, and codifies current medical necessity standards established by HCFA Ruling 85–2. The Tanner-Hulshof bill, although relatively recently introduced, already has more than 150 cosponsors. Members of Congress have become keenly aware of the adverse consequences to date emanating from the 75% Rule. We urge this Committee to address this problem and provide time sensitive legislative relief in the first moving Medicare legislative vehicle considered by this Committee. AMRPA strongly urges Congress to enact the provisions in H.R. 1459 as soon as possible this year to halt the continued hemorrhaging of this sector.

Unlike the recommendations seen for SNFs and LTCHs, MedPAC recommended a positive 1% update in the market basket for inpatient rehabilitation hospitals and units for FY 2008. The IRH/U field cannot absorb additional resource cuts that would further heighten volatility and threaten access to care as IRH/U beds, units, and hospitals. We urge Congress to support a positive market basket update for inpatient rehabilitation hospitals and units in FY 2008.

Finally, the field is prepared to work collaboratively with Congress, CMS, and the other sectors of the post-acute care world to define together an appropriate continuum of care, the distinctions among the various segments of the provider community, the criteria that should be used to guide patient placement and Medicare coverage decisions. The field also supports the need for research to be conducted and supported to create evidence that should be used to guide public policy.

We know Congress and this Committee face difficult payment system decisions. We seek favorable consideration by your Committee, and we pledge to work with you and your staff, and CMS. AMRPA and its members are convinced that if we work together, we can shape a rational and better health care delivery system that improves outcomes, increases access, more accurately places patients in appropriate settings, and reduces the true costs to the Medicare program and beneficiaries alike. We appreciate the opportunity to appear today, and I would be pleased to respond to any questions.


Inpatient Acute Medical Rehabilitation Discharges Per 12 Month Periods
Updated May 8, 2007
Actual or Projected Non-Medicare Patients
Actual or Projected Medicare Patients
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
191,040
458,678
194,453
469,371
188,484
434,747
185,026
384,120
188,444
351,091
182,187
331,027
171,664
287,546
Q3,02-Q2,03*
Q3,03-Q2,04*
Q3,04-Q2,05*
Q3,05-Q2,06*
Q3,06-Q2,07**
Q3,07-Q2,08**
Q3,08-Q2,09**
*Actual patient volume calculated from data supplied by UDSmr and eRehabData for 70% of patients.
**Projection of patients (both Medicare and Non-Medicare) accessing IRFs based on actual patient volume for 129 IRFs (20% of discharges nationally) in eRehabData for Q1 2007



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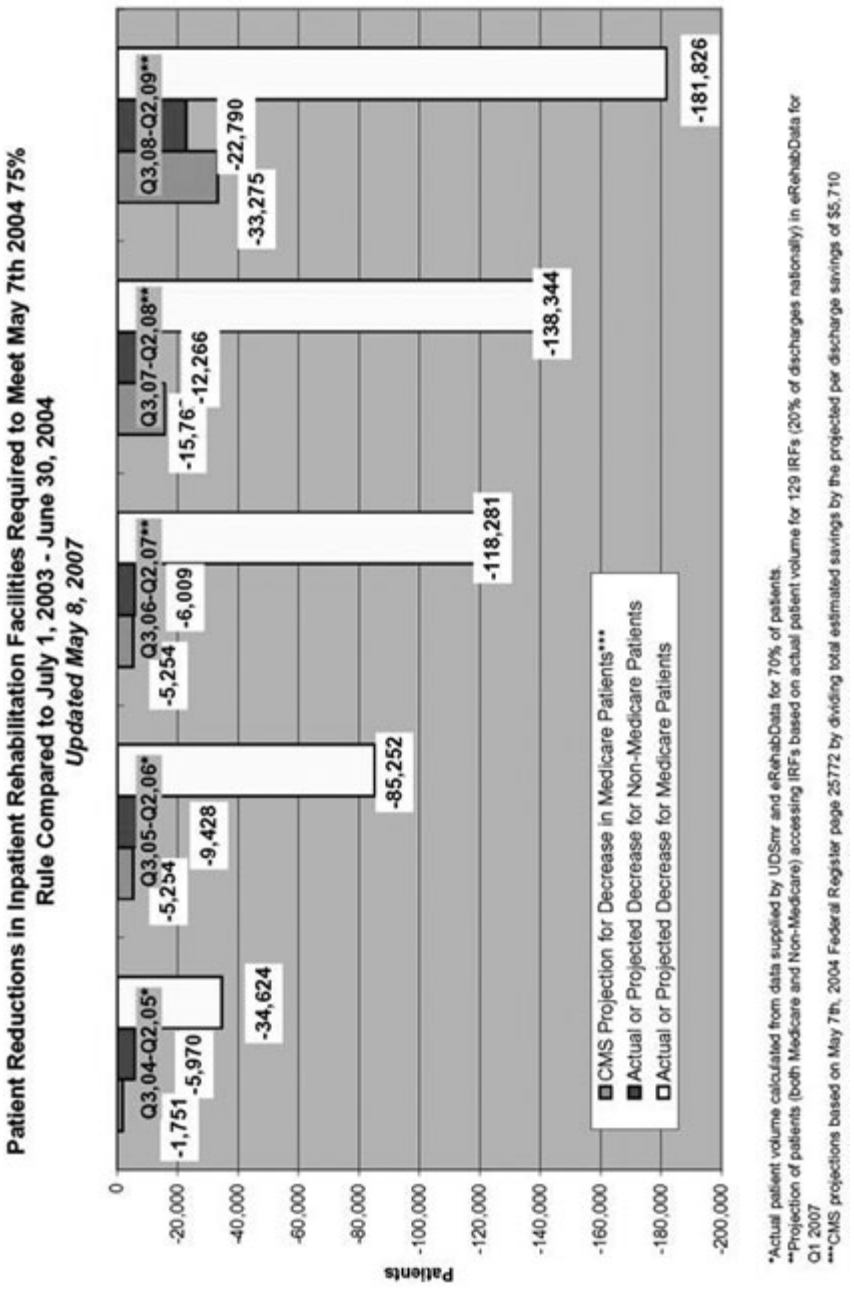
***CMS projections based on May 7th, 2004 Federal Register page 25772 by dividing total estimated savings by the projected per discharge savings of $5,710



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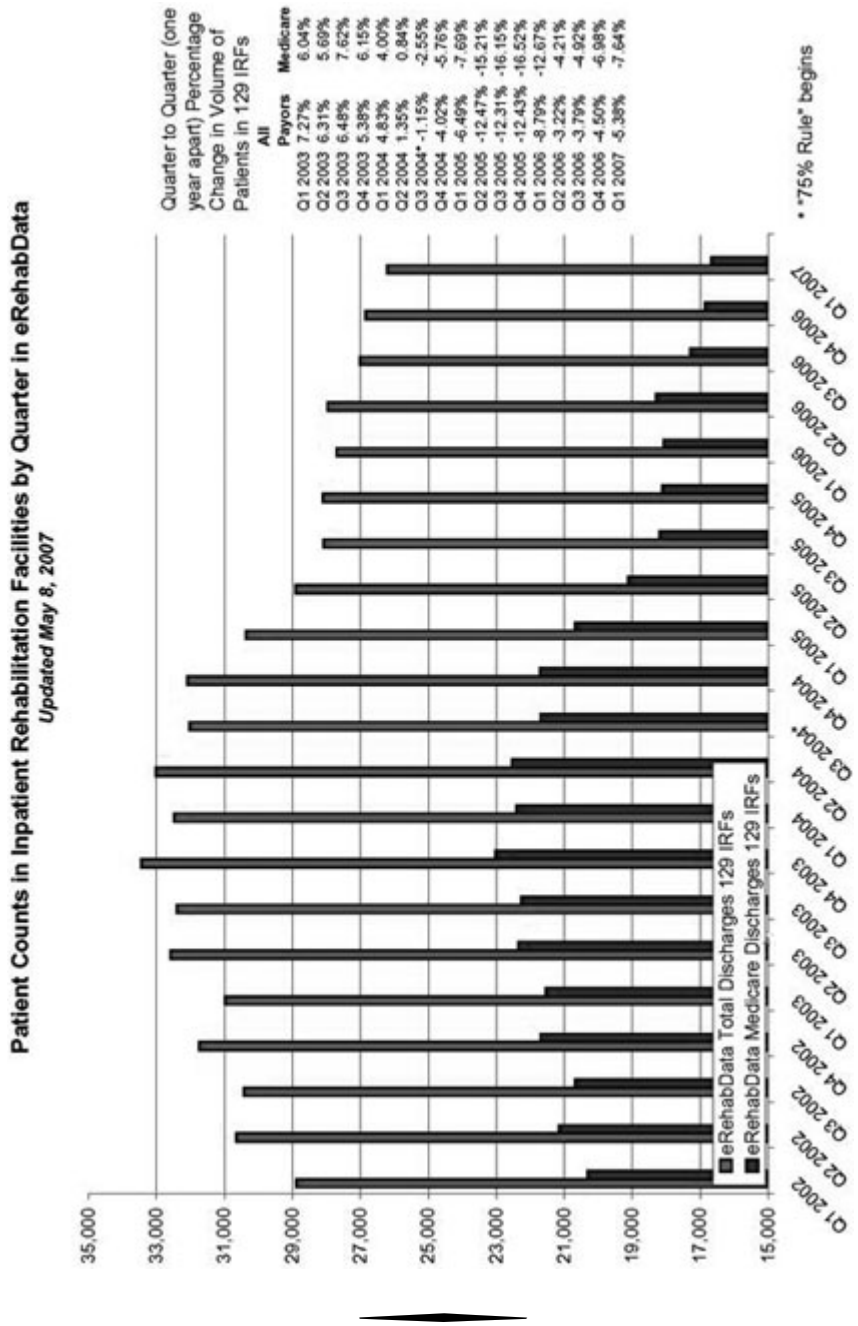
Patient Counts in Inpatient Rehabilitation Facilities by Quarter in eRehabData
Updated May 8, 2007
Quarter to Quarter (one year apart) Percentage Change in Volume of Patients in 129 IRFs
All Payors
Medicare
Q1 2003 7.27% 6.04%
Q2 2003 6.31% 5.69%
Q3 2003 6.48% 7.62%
Q4 2003 5.38% 6.15%
Q1 2004 4.83% 4.00%
Q2 2004 1.35% 0.84%
Q3 2004* -1.15% -2.55%
Q4 2004 -4.02% -5.76%
Q1 2005 -6.49% -7.69%
Q2 2005 -12.47% -15.21%
Q3 2005 -12.31% -16.15%
Q4 2005 -12.43% -16.52%
Q1 2006 -8.79% -12.67%
Q2 2006 -3.22% -4.21%
Q3 2006 -3.79% -4.92%
Q4 2006 -4.50% -6.98%
Q1 2007 -5.38% -7.64%
* "75% Rule" begins
eRehabData Total Discharges 129 IRFs
eRehabData Medicare Discharges 129 IRFs
35,000
33,000
31,000
29,000
27,000
25,000
23,000
21,000
19,000
17,000
15,000
Q1 2002
Q2 2002
Q3 2002
Q4 2002
Q1 2003
Q2 2003
Q3 2003
Q4 2003
Q1 2004
Q2 2004
Q3 2004*
Q4 2004
Q1 2005
Q2 2005
Q3 2005
Q4 2005
Q1 2006
Q2 2006
Q3 2006
Q4 2006
Q1 2007

Chairman STARK. I want to thank the entire panel. I just very quickly—we as a Committee I suppose could do nothing, and then the doctors would take that 10 percent dip in their fees and the three of us wouldn't be able to get medical care any place in the United States that we would feel comfortable asking for it.

On the other hand, we can begin to follow a variety of recommendations and cuts across the board. To the extent that that's all we can do, I think sometimes we fail to provide it. It's not easy to write legislation that applies equally in Louisiana, Michigan, California and North Dakota for example. There are different needs, different practice patterns, different requirements.

To the extent that you all representing your various groups can help us determine how we sort the wheat from the chaff, Bruce, you indicated that there are some units that do better than others. Teaching hospitals have a particular need. Rural hospitals in many cases have a need.

Not all long-term care facilities, Ms. Chesny, have negative margins. Some in the old days maybe had a 16 percent margin. That's different from somebody who has a zero to negative margin.

But you have to help us determine how best we can write legislation that does sort this because if we try to be as fair as we can—people are talking about—I don't know who keeps leaking this, I suspect it's Dave, that I am bound and determined to cut $50 billion or save $50 billion so we can fund SCHIP. Well, probably if we fund SCHIP the majority of that goes back to providers, more children's hospitals, more pediatricians. This is kind of a zero sum gain, and it is not easy for us.

Now to your credit and the credit of the American Medical Association, the California Medical Association, almost all of the providers have come to us, I don't know whether Mr. Camp has had the same experience, and said they recognize that this is not going to be a year of huge financial increase. As a matter of fact, some are predicting that they may not get every nickel that either the president's budget or MedPAC recommended.

I don't quite know how we're going to adjust to that to get a vote that will get us through the House and the Senate and get the President to sign. But without your help we'll make a mess of it because we could be pushed as one particular group of providers is suggesting they don't want to be in the room.

Well, without being able to determine who's better and who's worse, who's more deserving and less deserving, the only alterative left to us is across the board cuts. I don't like those. I don't think they—we're apt to harm people that ought not to be harmed and not help the people who need help.

So, that's a long-winded way of saying you all could be helpful to us. You don't have to endorse cuts but you could help us learn how to determine what the priorities ought to be as between the competing interests in your own group, whether it's rural long-term care providers or home health or whether it's inner city home health. There's a difference I think in the costs and the problems faced.

So, I'm asking you for more than just the excellent testimony you've given us today but to help us and help our staff as you used to help Chip figure out we can make these decisions and balance

the interests of the providers, the beneficiaries and the taxpayers. My measure is usually when everybody on the Committee is scowling we've got the right mix and that's when we ought to drop it down a little. If anybody is smiling, they're taking home something that the rest of us don't know about.

Let me just ask you to run down the line here and ask if each of you care to or have experience with Medicare Advantage and how the Medicare Advantage payments compare to payments under traditional fee-for-service programs, and do you have any problems with beneficiary access or any other problems with Medicare Advantage that we might look for. If you don't, don't bother.

Chip.

Mr. KAHN. Though the Medicare Advantage payments are lower than Medicare payments I think the issues with Medicare Advantage though go to the question of fairness and equality between beneficiaries. I think we have the situation today where we want to have—I think we want to have as a country a Medicare Program that gives people the options to have the kind of coverage they had when we were privately employed or before they retired, but I think we have to examine how much that option is worth in terms of equality between Medicare beneficiaries.

Chairman STARK. Mr. Umbdenstock.

Mr. UMBDENSTOCK. Mr. Chairman, we hear from our members in three areas around Medicare Advantage. Number one, in the private fee-for-service plans there's a lot of confusion as to what's covered, what's not covered, what benefits the members have, and they often show up at our front door or ER not aware of that and we only find out—and they find out later.

Another area of significant concern that we hear a lot about is from our rural members where the Medicare Advantage Plans are not paying the critical access hospitals the way the traditional plan is and that causes significant challenges for our members.

The third, your comment about where to maybe look for opportunities for savings has already been brought up in my comments and in Stan's around the issue of the payments to indirect, on indirect medical education. To those plans we think there's a legitimate place to look there as well.

Chairman STARK. Bruce.

Mr. YARWOOD. We're finding a very confusing pattern out there about long-term care because it's not the thing that people look at in terms of the advantage. The confusion first goes to a state like Arizona that has almost all HMO care.

What we saw in Arizona was the diminution in terms of bids of about 30 to 40 percent in a period of four or 5 years. Then you get into the question—and I'll just continue using examples—then you get into the question of the number of plans there with the different benefit structures, with the different payment structures and the different billings process that makes it extremely confusing patient to patient to patient.

We have one person that is an employee of the association that spends half her time trying to work with her member associations, with member facilities, going through and just working the billing process.

The second thing we find is that when you go into an area that may have excess capacity—I'll use the Bay Area, Kaiser, and if they go into a facility in Hayward that has six or seven beds open all of a sudden they're going to contract to put people into those beds at probably $50 to $100 less than the basic fee-for-service rate.

Why? Because you're making—if you compare it to nothing, you're getting something. Now the question then is can you get the staff to take care of that in the way necessary for those folks.

The third thing that I indicated in the testimony that we think is pretty unfair is the fact they have no 3-day hospital stay rule. People could go back and forth between facility and the hospital on a 1-day pattern or if you have a dual diagnosis where someone had a hip fracture, it was there for a while, they've used up their hundred days, they have diabetes and they have to get—again for the next—second hundred days, they have to go back to the hospital for 3 days, which is stupid, just stupid.

So, we find those kind of patterns, and as we start looking into it more and more and more we think that there will probably be some recommendations coming from us as to how to improve the system with us.

Chairman STARK. Thank you. Mr. Brezenoff?

Mr. BREZENOFF. I strongly endorse and support the comments that have just been made. I would only add that it is clear that we get less money from the Medicare Advantage plans than we do for fee-for-service. The obvious question is what's happening for that richer premium that the Medicare Advantage organizations are getting. Do we see it in the improved care or improved access?

The best case answer is we don't know and the worse case answer is that it's reflected more in the bottom lines of these organizations. In New York state it is very clear to us that the Advantage plans have much fatter bottom lines disproportionally because of what they get from the Medicare Advantage premiums, and it's not translated into reimbursement for hard pressed teaching hospitals, and it is not clear that it's turned into improved access or benefits for the covered lives.

Chairman STARK. Ms. Chesny.

Ms. CHESNY. Our experiences at the home health benefit end are Medicare Advantage is not the same benefits as a Medicare fee-for-service patient has. It's administered under the Medicare Advantage plan as a per visit benefit instead of a per episode benefit. Therefore the utilization responsibility often falls either to the managed care organization on each separate encounter under home health or what happens is the patient is subjected to copayments that can be as high as 50 percent for an out of network provider, and they ration their own care.

So, it's a complement of the benefit being changed—we also see prior authorization being a significant impact on medical necessity. The doctor is taken out of the picture. The nurse and the physical therapist's judgment is taken out of the picture. It's really administered by the dollars in the managed care organization. So, we see a significantly different Medicare benefit under Medicare Advantage.

Chairman STARK. Dr. Walsh.

Dr. WALSH. I think it's all been said. First, I don't have any aggregate data here to speak for the entire organization, but speaking for my hospital it is a very different benefit.

Patients when they sign up have the notion—and I don't know if it's misrepresentation or not but they have the same Medicare benefits, so that after an acute care stay for an accident that they didn't plan and therefore had not anticipated, if they are told that we don't cover inpatient rehab for, in this case it was pulmonary rehab, and I was surprised that their case manager knew that because I didn't think it was pulmonary rehab; they had no intrinsic lung disease; they had a lot of medical things and couldn't get out of bed. That was a surprise.

So, I think in terms of the confusion for the beneficiary about what their benefit now is—is terribly important. Secondly I think that the plan's attempt to negotiate a rate that wouldn't meet the costs is going to create other access problems.

Chairman STARK. Thank you all. Mr. Camp.

Mr. CAMP. Well, thank you, Mr. Chairman. Mr. Umbdenstock, I know some of your members have Medicare Advantage plans. Is there a value in those plans with coordinating care and other benefits that come under Medicare Advantage.

Mr. UMBDENSTOCK. Pardon me, Mr. Camp. I think the key question is what is the benefit of the extra payment that goes to the plans and how is it being used. If it's being used to highly coordinate care to the benefit of the patient for a true clinical integration of services and at the same time achieving financial results, that's a very good thing for everybody in terms of stretching those dollars.

So, I think the question that we'd all want to explore is exactly what models work best, what are the best practices in care coordination and how can we see that all the plans employ those for everybody's benefit.

Mr. CAMP. Thank you very much. Ms. Chesny, why are the margins for home health services different in freestanding home health agencies than hospital or skilled nursing facility-based agencies? I know you mentioned that MedPAC's financial analysis was at best incomplete because of the difference there. Can you talk about that a little bit?

*Ms. Chesney. I believe that home health agencies that are affiliated with hospitals and skilled nursing facilities tend to take care of patients that are higher in costs, more resource intensive and carry just an overall cost burden. They tend to be located in more geographically disbursed areas, and therefore their cost structure is much higher.

Our own agency, we've tried to be as efficient as we possibly can and we still look at a 2.8 percent margin in home health and that's an improvement for us. We were below zero 3 years ago, prior to tele-health implementation.

Mr. CAMP. I know you and I have obviously worked together on the tele-health issue. I know for example in rural home health agencies the transportation costs can be significant, particularly covering an area as large as 11 counties in the state of Michigan and other areas. Can you talk about that a little bit and how that may have changed in recent weeks?

Ms. CHESNY. I can tell you that we reimburse the IRS allowable mileage to our staff. It's a quality of life issue for our staff. We ask them to drive numerous miles on a daily basis. We average 22 miles per patient visit, and that is after we've improved our productivity with the augmentation of tele-health and technology for our staff. We used to be close to 30 miles a visit for most of our patient care.

So at 48-and-a-half cents IRS and then we now have gas that's sitting at $4 a gallon. I don't think that allowable is going to quite sit at the same place and so our costs will only rise again.

Mr. CAMP. All right, thank you.

Mr. Kahn, many providers in the LTCH community have called for an implementation of a criteria-based assessment. I don't know if you were here for the testimony previously, there was some discussion of that then. Can you talk about what kind of patient is best served by an LTCH and how that might differ from the care offered in an inpatient rehab hospital or a skilled nursing facility?

Mr. KAHN. Most of the patients in long-term care hospitals are on ventilators. I've been to a number of these institutions and the LTCHs have the kind of staff, the kind of knowledge about these patients, particularly if they're going to be on ventilators for a lengthy period of time that well serves the very complex cases, particularly as I said, those cases that will be on ventilators for a long period of time.

So, we feel there is a difference between the level of care there and other institutions. It warrants better criteria. It warrants the kind of system that the legislation that's been proposed envisions and the kind of arbitrariness of the CMS policy is not the kind of backstop you need in terms of moving this type of benefit to a point where we get the right patient to the right place.

I think the 25 percent rule is really wrongheaded as a way to get us there.

Mr. CAMP. Ms. Chesny, there was a discussion about case mix creep and you said that obviously some of the patients are on average older now than they used to be, but isn't it also correct that your pattern of care is physician ordered?

Ms. CHESNY. Yes, all of our services are required to be ordered by a physician. What we've seen, not only is it that our patients are older and more frail. As the payment changes have gone in place, for instance the inpatient rehab facilities, our orthopedic patients volume has increased significantly. There is a higher case mix weight with that. We went from having orthopedic being like the best, highest volume patient we have to now they're in a close contest for the second place. Right now, this year it's third place.

Cardiac patients, cancer patients and orthopedic patients are the patients we're seeing most in home health. Those are all very sick patients that we're caring for, so it's a different population.

As we were preparing the testimony, I have to tell you, I said to the National Association for Home Care staff, this system was designed in the '90s and the patient we are seeing today is not your father's Oldsmobile. It's a different patient that we are seeing from 1997 when the Prospective Payment System was designed. It is, I believe, a much sicker patient who requires a much more intense service, and the system isn't being abused.

We averaged 52 days to 45 days for the average patient on our Medicare home health episode. We're not seeing them for extended periods of time. We're teaching them to take care of themselves and we're rehabilitating them so that they can become as productive as they possibly can in their activities of daily living.

Mr. CAMP. Thank you very much, Mr. Chairman. Thank you all for your testimony. It was very helpful and I sure appreciate it. Thank you.

Chairman STARK. Again, I would invite all of you to elaborate some more to help us in the next month, 6 weeks, 2 months as we have to see if we can cobble together some legislation that will deal with all of these issues. It's going to be a busy summer for us. We appreciate your help.

I do appreciate you taking the time and the patience again of waiting for us. I'm sorry that we ran so late this afternoon, but thank you all very much.

Hearing is adjourned.

[Whereupon, at 4:54 p.m., the hearing was adjourned.]

[The submissions for the record follows:]

Statement of American Association of Homes and Services for the Aging

The American Association of Homes and Services for the Aging (AAHSA) appreciates this opportunity to submit a statement for the record of the House Ways and Means Health Subcommittee's hearing on Medicare payments to health care providers, including nursing homes and home health agencies.

AAHSA members serve over one million people every day through mission-driven, not-for-profit organizations. Seventy percent of our members are faith-based. Our members offer the continuum of aging services: home and community based programs, adult day programs, continuing care retirement communities, nursing homes, assisted living, and senior housing. AAHSA's vision is for all Americans to receive the care they need, when they need it, in a place they call home.

President Bush's budget proposal for fiscal year 2008 called for a freeze on Medicare reimbursement to nursing homes and home health care providers. We urge the subcommittee to reject this proposal, which would penalize the very health care providers who are making the greatest effort to ensure high quality care for frail older people.

CMS itself has projected that the cost of the items and services that skilled nursing facilities and home health agencies must buy will increase by 3.3% and 2.9% respectively over the next year. Since long-term care is a labor-intensive service, failure to provide the payment update CMS has proposed will have severe implications for providers' ability to recruit and retain the staff essential to meeting Medicare beneficiaries' needs.

Skilled nursing facilities—the not-for-profit difference

Approximately 70 percent of payments nursing homes receive come from the Medicare and Medicaid programs. Very few nursing home residents currently have private insurance to cover the cost of their care. This heavy reliance on these two programs makes their payment policies even more critical to nursing facility operations than they are for health care providers that have more varied sources of payment.

The average non-profit home cares for about 10–20 Medicare patients each day. The proposed cuts translate into the loss of $100,000–$200,000 annually for the average home and much more for those that specialize in Medicare's high need patients. There just are not sufficient "excess" dollars in the system to make up these losses. Forcing nursing homes to "economize" even further on nursing staff and wages—inevitable with cuts of this magnitude since nursing is 40% of total costs—would be bad for Medicare and bad for patients.

Adequate Medicare reimbursement makes a major difference to nursing homes' ability to recruit and retain staff, the single greatest determinant of the quality of care facilities are able to provide. According to reports the Medicare Payment Advi-

sory Commission has submitted to Congress for the last two years, not-for-profit nursing facilities spend substantially more on nursing staff than for-profits and therefore have low to zero profit margins on the Medicare payments they receive. For 2005, MedPAC found that for-profit nursing facilities achieved margins of fifteen percent on the Medicare payments they received, while not-for-profits' margins were below five percent.

Denial of a payment update to facilities that already are struggling to break even on the services they provide to Medicare beneficiaries would run directly counter to the many initiatives we are pursuing to raise nursing home quality. Facilities that are achieving high margins through skimpier staffing would be hurt far less by the denial of a payment update than facilities that have committed maximum resources to providing quality care to frail older people.

Furthermore, the proposal to deny nursing facilities a payment update is a false economy. A ten year study, conducted by HHS at the request of Congress, on nurse staffing in nursing homes found that homes with less than optimal nurse staffing had significantly more avoidable hospitalizations than those with appropriate nurse staffing (USDHHS. *Report to Congress: The Appropriateness of Minimum Nurse Staffing in Nursing Homes,* 2002). The fewer the nurses, the higher the rates of avoidable hospitalizations. Every avoidable hospitalization costs Medicare an average of $7,600. An increase of just 13 avoidable hospitalizations per skilled nursing facility would wipe out the $1.5 billion in Medicare "savings" from cutting SNF rates.

Because payment policies are so critically tied to adequate staffing, we recommend that the subcommittee adopt a proposal that was introduced in the last Congress by Rep. Marcy Kaptur to require nursing facilities to make itemized reports to the Centers for Medicare and Medicaid Services (CMS) of the amounts they spend annually on staffing. This requirement, contained in H.R. 1166, would be a promising first step toward better aligning the Medicare program's payment incentives with the quality of care provided in nursing facilities.

Medicare's Perverse Payment Incentives for Skilled Nursing Care

The subcommittee also needs to revisit the deeply flawed final rule CMS issued in 2005 to "refine" the skilled nursing facility prospective payment system. The system is based on Resource Utilization Groups (RUGs) that still do not accurately determine acuity of need and responsibly calculate the cost. This is particularly true for medically complex patients who generally require not only extensive nursing care but also significant amounts of medications, supplies, tests, respiratory care, and other so-called "non-therapy ancillaries." Medicare reimburses skilled nursing facilities for many very expensive patients at considerably lower rates than Medicare pays for patients whose care costs much less. The Inspector General, MedPAC, and the GAO have all reported on these inaccuracies.

Specifically, the revised RUG system poses the following problems for nursing homes and their residents:

Quality of care

- The system creates strong financial incentives for nursing facilities to find patients who qualify for the nine new RUG groups created by the 2005 rule.
- To qualify for the nine new (higher) payment groups, patients must be assigned to intensive physical therapy and to "Extensive Services." The "Extensive Services" designation requires that the patient have an activities of daily living score greater than 7 and have had intravenous medications, ventilator or respirator care, a tracheotomy or suctioning within the last fourteen days, or intravenous feeding within the last seven days, even if these treatments were given during hospital stays.
- There is intense financial pressure on facilities to "find" such patients, because otherwise facilities may have substantial financial losses in their Medicare reimbursement.
- The availability of patients qualifying for the new RUG categories depends heavily on local hospital practices, particularly as to how frequently intravenous medication (rather than oral) is ordered. Hospitals seeking to find a skilled nursing facility for patients who are being discharged will soon learn that Medicare payment rules favor patients who had an IV in the hospital. Practice patterns are likely to shift in ways that have more to do with perverse payments than with good clinical care.

There is no evidence that revised system improves payment accuracy; in fact, accuracy may actually be reduced.

- CMS cited only one piece of scientific evidence in the final rule in an attempt to justify the nine new RUGs and the contention that the new system is more accurate, as Congress required. But this bit of "evidence" is not relevant to the changes CMS actually made in the payment system and is the result of researchers studying a completely different issue.
- Increased payments are not targeted to medically complex patients who do not receive rehabilitation, even though their care can be very costly, with heavy use of non-therapy ancillaries.
- Also, non-therapy ancillary costs continue to be paid as if they correlated with nursing costs, which research has repeatedly shown is not the case. CMS itself noted that the new payment system would not account accurately for non-therapy ancillary costs, and that the addition of nine new RUG categories didn't solve this discrepancy. CMS attempted to solve the problem by applying the same small increase in the nursing index across all RUG groups, about three percent of total revenues. But because the payment system doesn't accurately cover non-therapy ancillaries or correlate to the nursing index, the payment system still does not accurately correlate costs of care with payment rates.
- CMS used tiny samples of patients who classify into the new RUG groups in doing its data analysis. For three of the new RUG groups, payments for millions of Medicare days are being set based on what happened to fewer than ten patients in a small number of facilities nine to twelve years ago. Among other problems, this use of small samples risks destroying the accuracy of the current payment system's correlation of payment rates to nursing and therapy staff times.
- In doing its data analysis, CMS mixed apples and oranges, using some numbers from Abt Associates and other numbers from the Urban Institute. Each of these studies used different databases, different analytical techniques, and likely different trim points.

Congress should require CMS to go back to the drawing board on the skilled nursing facility prospective payment system to ensure that it more accurately reflects the true costs of caring for frail elders.

Home Health Care

An estimated 83% of older Americans who have long-term care needs live in non-institutional, community-based settings. Medicare covers the skilled nursing care, home health aide service, physical therapy, speech-language therapy and occupational therapy in the home after a hospital stay. These services are critical for the patient to remain independent at home. Home health agencies reduce the risk of a re-admission into the hospital, as well as nursing home placement.

In addition to ensuring that home health agencies receive the payment update that CMS has proposed for next year, we urge Congress to review the plans to overhaul the home health prospective payment system. Home health agencies provided quality services despite many years with no payment updates until 2006. In 2008 most agencies would experience a 2.75% reduction annually over three years in the Medicare base payment rate under the revised payment system. Twenty percent of all home health agencies already are operating in the red. This reduction in reimbursement rates could reduce the availability of vital home health services for seniors and the disabled.

Home health care providers need sufficient funding to recruit and retain quality staff, invest in telehealth technology and meet escalating transportation costs. Eliminating the 5% rural add-on has already had a negative impact on rural home health agencies. These agencies are estimated to experience a decrease in their average case mix from 1.583 to 1.1417. Twenty-three percent of older Americans live in rural areas, and we need to have these services available for them. CMS also predicts that home health agencies in the South would experience a 1.84% decrease in 2008 under the new payment system. CMS is proposing a $2,300.60 national average base rate for 2008, down from this year's $2,355.96 for 2007 episodes. But even after a 2.9% inflation update worth more than $400 million in 2008, these changes would add up to $7 billion in lost Medicare revenues over five years.

We appreciate that the proposal would allow severity-adjusted amounts of up to $367 per episode for non-routine medical supplies, add nearly 60% of the Lower Utilization Payment Adjustment (LUPA) episodes to cover admission costs and eliminate the episode payment adjustment for a significant change in condition (SCIC) and for prior hospital stays. We also appreciate the guidance offered by CMS in changing to the new and more complicated case mix process.

State Medicaid programs are struggling to meet the increasing demand for home health services for older adults and the disabled. The budget proposes legislative

changes in Medicaid that would reduce Federal Medicaid funding by $25.7 billion over the next five years, of which $20.9 billion would be achieved by shifting costs to the states. The cost shifts include a reduction of the Federal matching rates for all administrative activities and for targeted case management services. Medicaid and Medicare cuts in home health services are reducing our ability to meet the goals of the New Freedom Initiative, the Money Follows the Person programs from the Deficit Reduction Act, as well as the vision of the future of aging in America that was announced at the White House Conference on Aging in 2005. We look forward to working with your committee and CMS to assure that older Americans and people with disabilities can obtain quality home health services, so they can remain healthy and independent in their own homes.

Medicare Therapy Caps

One Medicare payment policy that must be addressed this year is the annual cap on coverage of outpatient physical, occupational and speech therapy. These caps are enormously counterproductive to quality care and efforts to keep Medicare beneficiaries living as independently as possible.

Therapy needs have increased as the population ages and people live longer. Limiting the therapy that one can receive in a particular year often hinders an individual's ability to regain physical strength and daily living skills that are required to live independently. In addition, an individual may exhaust his or her permitted therapy early in the year and have a new need for therapy later in the year—as a result of a new medical setback (surgery, injury from a fall, heart attack, etc.)

In the ten years since the therapy caps were enacted under the Balanced Budget Act of 1997, Congress has allowed them to be fully effective for only a few months. Congress itself has recognized the danger of limiting essential therapies for beneficiaries with serious injuries and health conditions. While the Congressional Budget Office scores repeal of the therapy caps as being costly to the Medicare program, this analysis does not take into account the hidden costs that may result from limiting essential therapy services. If a Medicare beneficiary fails to regain full functioning and suffers a serious fall or otherwise comes to need higher levels of care, the potential cost to the Medicare program could well exceed whatever savings are achieved through the therapy caps.

We recognize the need to ensure that therapy services, like other forms of health care, are only covered by Medicare to the extent that they are medically necessary. CMS for several years has pursued a Medicare integrity initiative under which waste, fraud and abuse in the Medicare program have been successfully prosecuted and inappropriate payments recovered. According to CMS, this initiative has resulted in the recovery of many billions of dollars over the years in which it has been in effect. Applied to therapy services, the integrity initiative should be more than sufficient to detect, prosecute and prevent any improper use of the benefit.

We therefore urge Congress to enact the Medicare Access to Rehabilitation Services Act of 2007, H.R. 748, which would repeal the Medicare outpatient rehabilitation therapy caps. This legislation would ensure that beneficiaries are able to obtain therapy services for which they have a medical need in the setting that is most appropriate for them.

Need to examine entire long-term care funding system

We recognize that today's hearing concerns the appropriateness of Medicare reimbursement to health care providers, and that a different House committee has jurisdiction over the Medicaid program. However, in the real world of long-term care, the payment policies of both programs are crucial to facilities and agencies that serve vulnerable elders. For the immediate future, we urge this subcommittee to act on the proposal contained in Rep. Kaptur's bill from the last Congress that would require CMS to analyze and report to Congress on all of the issues affecting nursing facility costs and funding, including the adequacy of Medicaid funding now and in the future to pay for the quality of care mandated by state and Federal law and regulation. In the longer term, Congress must reevaluate how to pay for long-term care services. AAHSA has developed a financing plan this is both socially and fiscally responsible, and we would be happy to work with the committee on this issue.

Conclusion

The denial of a payment update to skilled nursing facilities and home health care providers would impose a severe hardship, especially in the not-for-profit sector, making it extremely difficult for facilities to meet the costs of staffing and other elements of high-quality care. Data from CMS and MedPAC themselves indicate the need for a payment update in the next fiscal year, and Congress must allow the update for which current law provides.

Striving to provide the highest quality of care, not-for-profit nursing facilities and home care agencies are spending every dollar of reimbursement they receive from Medicare on staffing and other essential components of quality. The denial of a payment update would be a heavy blow to these providers, their staff, and the vulnerable old people they serve.

Instead of taking the easy route of across-the-board payment cuts, we urge your committee to thoughtfully evaluate the skilled nursing and home health payment systems and redirect their incentives toward encouraging continuous improvement in the quality of care Medicare beneficiaries receive. We look forward to working with the committee in this effort.

Statement of Keith G. Myers

The LHC Group appreciates the opportunity to provide testimony on behalf of its patients and caregivers concerning payment systems for fee-for-service providers. The LHC Group is a provider of post-acute health care services primarily in rural markets in the southern United States. We provide home-based services through our home nursing agencies and hospices and facility-based services through our long-term acute care hospitals and rehabilitation facilities. These services are provided by a trained staff of over 3600 nurses, physicians, therapists, and aides throughout our locations in Texas, Louisiana, Mississippi, Arkansas, Alabama, West Virginia, Kentucky, Florida, Tennessee, and Georgia. We share Medicare's mission of providing care in the least restrictive, most cost-effective, and most appropriate environment possible.

> *The ability to have home health in rural areas provides Mother the luxury to stay at her home and get excellent care. Home health has made her life easier. It has been beneficial to me and her family. We know she is in good hands. They are all so caring and they are always available. For a person Mother's age, staying in her familiar surroundings helps her mentally, physically and spiritually. If these services are cut, or the reimbursement is not adequate for services to continue to assist in providing the nurses to care for Mother, she would have to go to a nursing home. I know she would not last two weeks. It is cheaper for us to have her at home than in a facility. I feel the secret to longevity is the ability to receive home care.*—M.W., Mississippi

I. OVERVIEW

Each day, home health agencies that provide essential clinical and supportive care services to Medicare beneficiaries in America's rural areas stretch limited resources far and wide to meet the unique needs of the patients they serve. Historically, Congress and the Centers for Medicare and Medicaid Services (CMS) have asked rural home health agencies to do more with less, a demand the rural home health provider community has largely met. Today, providers who serve rural beneficiaries continue to face new challenges that that they cannot meet alone. They need help from Congress.

In April, CMS issued a proposed rule detailing a far-reaching restructuring of the Medicare home health prospective payment system. If finalized in its current form, the rule will threaten the ability of rural home health agencies—already faced with higher costs and lower reimbursements than urban agencies—to continue to provide services to rural residents.

Historically, Congress sought to mitigate both the financial pressures on rural home health agencies and the related access barriers encountered by rural residents through the creation of a special payment adjustment, or "add-on," to the prospective payment system's base payment rates. Congress authorized the payment adjustment for home health services delivered in rural areas during most of the period from April 2001 through December 2006, and the add-on greatly assisted providers' ability to meet rural resource needs that are different, and more costly, than those in urban areas. However, the rural add-on expired on December 31, 2006 and has not yet been reauthorized.

In this testimony, we illustrate the urgent need for reauthorization of the rural add-on. We detail the economic and clinical access challenges that the proposed rule imposes on health care in rural America, highlighting the adverse impact of the proposed rule on rural beneficiaries and the home health agencies that serve them. We also discuss the policy rationale behind the rural add-on as well as its bipartisan history, and we conclude with a call for Congress to reauthorize the rural add-on and make it permanent.

II. RESTATING THE CASE FOR THE RURAL ADD-ON

A primary reason that rural home health agencies require the rural add-on payment is to help cover their operating costs, which are higher on average than urban agencies' costs. These higher costs result from a combination of factors, including the increased acuity of patients in rural agencies as well as other built-in additional costs of providing home health services in a rural setting—costs that urban providers do not carry.

A. More Complex Conditions

The service mix for home health beneficiaries in rural areas is considerably different than that in urban areas. Hospital care in rural areas tends to be focused on short-term, acute primary care with limited access to tertiary care centers and the specialty services they provide. Post-acute care providers in rural areas tend to treat a higher proportion of chronically ill patients than their urban counterparts. This basic difference in patient mix results in part from the different relative balances of provider types in rural and urban areas, and in part from the fact that rural Americans tend to be disproportionately older and have more chronic health problems than urban Americans.

Providing care to these elderly patients with multiple health conditions can be more time-intensive than serving other patients. This is illustrated by one home health nurse's discussion of treatment for an elderly patient with multiple comorbidities who lives with his elderly wife, who also faces several health conditions:

> *Home health nurses are required weekly to assess and literally be the "eyes" for the physician and, hence, to [implement] a rapidly changing treatment plan for his multiple diagnoses. To transport the patient is an extremely taxing and un-safe situation. The patient and his wife have no means for transportation, no local caregivers, and no economic resources. The physician agrees that the most vital part for safety of this patient and his wife is totally dependent on the assistance of the home health nurses.*—Anonymous, Louisiana

Beyond age and chronic illness, another reason for increased acuity among rural agencies' patients is the homebound status of many of these rural patients. Rural home health agencies frequently function as the primary caregivers for homebound beneficiaries, who have minimal access to transportation. This situation results in higher costs per patient and per visit, since homebound patients require more resources than patients who have access to other providers. One home health nurse encountered this situation when treating an elderly patient who lives alone and who was admitted to home care following a month-long hospitalization for a serious and extended illness. In this nurse's words:

> *The patient requires daily dressing changes, which she was unable to perform herself. She has no local family members but relies on neighbors and friends for transportation to receive medical care. However, many of her rural neighbors are also senior citizens and are limited in their ability to assist her. In the patient's eyes, her situation "would [have been] devastating had it not been for home care services."*— A.S., Alabama

Another home health nurse discovered the increased resource needs of homebound, high acuity patients when caring for a man with multiple chronic illnesses who had recently had a new tracheostomy and feeding tube put in place. This nurse described the homebound man's situation as follows:

> *The wife, who has dementia, is unable to provide or participate in the care of her husband. This patient requires daily visits from the home health nurse. In addition to daily visits made by the skilled nurse, their case manager consistently receives phone calls to coordinate care. The closest caregiver is the patient's granddaughter who has to travel a 100-mile round trip to their home. The couple has no means of transportation, and it is very taxing and risky for the patient to leave his home. The home health nurse is the primary caregiver to this couple. If this patient did not receive home health services he would have no access to health care and would have to be institutionalized to receive care.*—Anonymous, Louisiana

As the examples above demonstrate, elderly rural beneficiaries often face multiple health conditions that require near-constant care that their families are unable to provide. In addition, these patients are frequently unable to leave their homes to receive care either because they lack transportation or because their health conditions make transportation unsafe.

Many rural agencies also report an increase in more complex patients because of recent CMS restrictions on admissions to other post-acute care providers. In particular, the recent tightening of admission criteria for inpatient rehabilitation facilities and inpatient long-term acute care hospitals has resulted in more patients receiving treatment in the home setting.

These facts in combination result in a higher acuity patient mix for rural than for urban home health agencies, and treating these patients, in turn, requires more costly resources in terms of staffing, medications, and other treatments. While these patients desperately need care, the many financial strains on rural agencies may ultimately force some agencies to turn away these resource-needy homebound beneficiaries because of resource limitations.

B. Special Structural Challenges

As demonstrated above, rural home health agencies experience some additional costs because of their patient mix, which itself is a result of the structure of the broader health care marketplace and of regional behavior trends in rural areas. Other additional costs of rural home health agencies depend less on the particular service requirements of the agencies' patient populations and more on the structural issues raised by the provision of home health services in rural areas. These structural considerations, in combination with more complex patient conditions, further demonstrate the need for the rural add-on.

1. Greater Driving Distances

Home health agencies in particular experience significantly higher costs in providing care to rural beneficiaries because the services are provided in the patients' homes and not in an institutional setting. Rural beneficiaries are scattered throughout rural areas and not congregated in cities like their urban counterparts. This results in increased personnel costs and decreased efficiency due to the longer drive times to reach rural residents. Compounding these extra costs are the increases in fuel prices and the additional visits necessary to ensure that rural patients without access to phone service comply with medication adjustments (which can be frequent for some high-acuity patients).

Although caregivers try to conserve costs by planning efficient driving routes, patient care needs often force them to change their plans. These obstacles to efficiency are detailed in one home health nurse's description of an ordinary day in rural home health service:

> *Due to multiple circumstances such as the high price of gas, and the distance from patient to patient, I have to strategically plan my geographical route for the day, to ensure proper patient care and timing of my visits. Unfortunately, there are multiple times where this plan does not unfold as planned. Numerous times I receive calls from my office, which changes my routine. There are patients that must be seen ASAP to avoid possible emergency room/hospital admission. When this does happen, I am forced to drive great distances, sometimes just to see a single patient. Once I get there, I have to take into consideration the multiple variables that I will be faced with to complete this extra visit. These include performing the initial assessment on the patient; after this assessment, my work has just begun. I am responsible for notifying the doctor of any changes in the patient's condition. At this point, I am responsible for implementing and executing any new orders from the doctor, which may include, but are not limited to, contacting the pharmacy for any medication changes, setting up lab work, x-rays, or any additional test. Any changes to the plan of care at this point must be reiterated through teaching to the patient/caregiver along with possible transportation issues. At times, this can be a daunting task due to the lack of appropriate resources in rural communities, along with the knowledge deficits of various patients and caregivers.*—Anonymous, Louisiana

Other home health nurses have overcome unique obstacles to reach rural patients. One such nurse writes that she has *"waded creeks, climbed over broken porches, and battled many a dog. Many of our aides have had to go to a well or a branch [office] to draw water and then heat it on the stove (or a hot plate) before they are able to bathe their patients."*—M.A., Kentucky. Another nurse recalls *"[being] attacked while riding on a rural road because [the driver] knew I was a nurse and was going to try to rob me," "having to run from dogs,"* and *"driv[ing] on gravel roads and get[ting] stuck in the mud due to bad roads."*—C.J., Mississippi. Yet another nurse often visited a patient who lived in a rural area across a river that, because it was unpredictably passable by vehicle, had to be reached *"by a swinging bridge that spanned the river. After reaching the end [of the bridge], the nurse would then have*

to walk on a narrow footpath that followed the riverbank, through the woods to the patient's home, toting supplies and equipment."—R.B., Arkansas

2. Smaller Agency Size

Rural agencies are often smaller than agencies in urban areas. Simple economics dictates that small agencies will have higher costs relative to larger organizations. Smaller agencies have fewer patients and fewer visits over which all the agencies' fixed costs of service provision—including costs of meeting regulatory requirements—can be spread. This results in higher overall costs per patient, per visit. Smaller agencies also are more likely than larger agencies to be faced with a homogeneous case mix, as they will have lower patient volumes than their larger urban counterparts. In such a situation, there will not always be enough even slightly profitable cases to counterbalance the high-cost, resource-demanding cases.

This problem is exacerbated by the fact (noted above) that rural agencies already serve a higher acuity patient population. Although the Medicare reimbursement system attempts to account for these high-cost patients through additional outlier payments, these payments are too low to cover agencies' actual service costs.

3. Scarcity of Skilled Professionals

Many home health agencies have difficulty getting certain health care professionals to service beneficiaries in rural areas. Some rural agencies have reported frequent use of nurses instead of therapists to provide rehabilitative services because of a lack of therapists willing and able to provide services in rural areas.[1] Unfortunately, when an agency substitutes skilled nursing restorative services for rehabilitative therapy services, it does not qualify for the higher therapy rates allowed under the home health prospective payment system.

III. DOING MORE WITH LESS IN RURAL AMERICA

To address these challenges, some home health agencies in rural areas have developed alternative operating models to reduce costs. They have been forced to do more with less.

Many agencies serving remote rural areas have established branch offices, or "drop sites," to minimize personnel drive times and to provide a local repository for supplies and records. While these types of remote locations do increase personnel efficiencies, any savings are often offset by increases in agency overhead costs for rent, utilities, and other expenses associated with operating a remote office. And, as noted above, these increased overhead costs are spread over a smaller number of patients, which intensifies the impact on the agency's finances.

Other agencies have sought to maximize personnel productivity by compensating their clinical staff on a per visit basis instead of a monthly or hourly basis. This method of compensation causes clinical staff to travel more efficiently between patient visits. While compensating on a per visit basis may help minimize the costs of providing care to home health providers, the caregivers themselves must incur the added cost of travel. As one caregiver noted, *"when it takes an hour or more to just drive from one patient to another, my productivity is obviously limited. Add to that the wear and tear on my car and you see that I get less in my paycheck than my urban counterpart."*—A.C., Florida. Per visit compensation, then, places agencies at a competitive disadvantage, often resulting in retention problems.

To address the scarcity of skilled professionals, most home health agencies are forced to compensate these professionals at higher rates than their urban or hospital-based counterparts. While this issue affects almost every professional discipline, the most commonly affected professionals are physical therapists, speech therapists, and medical social workers. The Medicare program fails to recognize this incremental increase in the program's area wage adjustments, yet the increase remains a significant extra cost of providing home health services to rural beneficiaries that urban providers do not bear. Additional discussion of regional wage discrimination follows below.

IV. INACCURACY OF WAGE-BASED REIMBURSEMENTS

In addition to facing higher costs than urban agencies, rural home health agencies receive Medicare reimbursements that do not adequately account for their labor costs, a problem the proposed rule exacerbates.

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[1] National Association for Home Care & Hospice (NAHC), "Maintain the Add-on for Home Health Services in Rural Areas" (*hereinafter* "Maintain the Add-on") (2004); NAHC, "Preserve Access to Rural Home Health Services" (*hereinafter* "Preserve Access") (April 2007), *available at http://www.congressweb.com/nahc/docfiles/RuralTalkPts07.pdf.*

A. Lower Reimbursement for Rural than for Urban Agencies

Inaccuracies in wage index values are the core cause of reimbursement distress for rural home health agencies, yet there are few opportunities for correction.

Medicare rural wage indices are uniformly lower than urban wage indices, a reality that results in substantially lower Medicare reimbursement to rural home health agencies for the same services, provided to the same type of beneficiaries, as compared to urban agencies. The national average Medicare wage index is set at 1.0. Addendum B of the final rule for the home health agency prospective payment system for calendar year 2007 shows rural wage indexes ranging from 0.7215 to 1.1709 for the 50 states with an average rural wage index of 0.8445 and a median of 0.8588.[2] Only seven states have a wage index over 1.0 (Alaska, California, Connecticut, Hawaii, Massachusetts, New Hampshire and Washington).[3]

Because Medicare reimbursement is based largely on CMS' estimation of differences in wages among geographic areas, the accuracy of reimbursement depends on the accuracy of CMS' calculations of wage rates. As mentioned above, rural agencies are often compelled to pay the same wages as urban agencies for therapists, whose services are required for the agencies not only to provide top-quality patient care, but also to qualify for certain higher Medicare reimbursements (i.e. for therapy visits). In addition, nursing shortages exist nationwide, which can force rural agencies to pay nurses wages on par with urban agencies to attract staff. CMS' failure to take into account this equivalence in wages between rural and urban home health agencies results in inappropriately low wage indices for rural agencies, for which there is no remedy other than the rural add-on.

B. No Access to Reclassification Relief or to Special Rural Payment Policies

In the hospital setting, a rural hospital with disproportionately high labor costs can apply for reclassification of its wage index. Such a hospital could, thus, be paid at the same wage index-based rate as an urban hospital that had the same wage rates. Home health agencies, however, are not eligible for reclassification. Moreover, the inequity is increased in rural areas in which a hospital can qualify as a critical access hospital or sole community provider—and receive higher reimbursements—while a rural home health agency in the same community has no access to these additional payments.

Rural home health agencies also lack access to other payment sources created by Congress to address the numerous challenges facing health care providers and Medicare beneficiaries in rural areas. For example, the Rural Hospital Flexibility Program re-established cost-based reimbursement for critical access hospitals. Small rural hospitals are still held harmless from the effects of the hospital outpatient prospective payment system. Physicians practicing in rural health professional shortage areas qualify for a 10 percent Medicare payment bonus. Rural health clinics and federally qualified health centers receive reasonable cost-based reimbursement for providing service to Medicare beneficiaries. None of these cost-management tools are available to home health agencies serving rural beneficiaries. Thus, home health agencies lack resources to correct the low wage indices assigned to them by CMS, which does not accurately recognize rural agencies' high labor costs.

C. Detrimental Effects of the Wage Differential

The dramatic reimbursement effect of rural wage indices is evidenced by the financial situation in rural North Carolina, which represents the median rural wage index:

National 60-day Episode Amount:	$2,300	
Labor-Related Share:	$1,766	[0.76775 * $2300]
Wage Index:	0.8588	[rural North Carolina]
Wage-Adjusted Labor Portion:	$1,517	[0.8588 * $1766]
Non-Labor Share:	$534	[.023225 * $2300]
Total Reimbursement:	$2,051	[$1,517 + $534]

[2] 71 *Fed. Reg.* 65884, 65936 (November 9, 2006).

[3] In 2004, CMS rebased and revised the home health market basket, resulting in a labor-related share of 76.775 percent and a non-labor portion of 23.225 percent. 69 *Fed. Reg*. 62126 (October 22, 2004). To calculate the reimbursement due a provider for an episode of care, the national 60-day episode rate is multiplied by the beneficiary's applicable case mix weight. The result is then divided into a labor and non-labor portion. The labor portion is multiplied by the applicable wage index based on the residence of the beneficiary. The total reimbursement due the provider for the episode is the sum of the wage-adjusted labor portion and the non-labor portion of the case-mixed 60-day episode amount.

This rural payment ($2,051) stands in contrast to the full payment of $2,300, which would be available if the wage adjustment were equal to 1.0—a difference of 10.83 percent, or $249, for the episode ($4.15 per day).

The range of the rural wage indices for the 48 states subject to a rural wage adjustment for this same example is as low as $1,808 in South Dakota and as high as $2,602 in Connecticut, as illustrated by the following calculations:

	South Dakota	Connecticut
National 60-day Episode Amount:	$2,300	$2,300
Labor-Related Share:	$1,766	$1,766
Wage Index:	0.7215	1.1709
Wage-Adjusted Labor Portion:	$1,274	$1,517
Non-Labor Share:	$534	$534
Total Reimbursement:	$1,808	$2,602

This represents a $794 difference for the same services, provided to patients with the same conditions who reside in rural areas, and provided by Medicare-certified home health agencies with the same case mix. The only difference in the two scenarios is the geographic location of the patient's residence.

D. Additional Concerns with the Wage Index System

Setting aside the concern about inaccuracies in wage index calculations, the home health provider community has long opposed CMS' use of the hospital wage index to establish home health wages. Differences in the personnel pool and costs between hospitals and home health agencies make use of the hospital index inappropriate in the home health setting, where the institutional efficiencies used by hospitals to spread costs are not available. Statewide rural wage indices do not accurately represent local labor markets because geographically disparate hospitals are treated together without regard to their true labor costs.

For rural home health agencies, inaccuracies in wage index values are made worse by differences in payer mix between the urban and rural settings. Because of the substantially higher proportion of poor and elderly individuals in rural areas, rural health care providers are primarily dependent on Medicare and Medicaid reimbursement. The financial stability of Medicare- and Medicaid-dependent rural agencies is essential in ensuring access to care for low-income beneficiaries in particular, as national benchmarking data indicate that rural home health agencies provide twice the amount of indigent care as urban home health agencies.[4]

V. RURAL BENEFICIARIES' RELIANCE ON HOME HEALTH AGENCIES

In the midst of increased costs and reduced reimbursements, rural home health agencies often find themselves as the primary providers of post-acute care services for rural Medicare beneficiaries. Research has shown that rural Medicare beneficiaries are less likely than urban beneficiaries to use institutional post-acute services, including skilled nursing facilities and inpatient rehabilitation facilities[5]—a trend attributable to patient preferences and to a lack of specialized post-acute care providers in rural areas. Additionally, it is recognized that rural beneficiaries do not receive the same level of physical and occupational therapy services as urban residents.[6]

Based on a recent study of the CMS Home Health Compare data, researchers determined that there are only minor differences in the quality of care provided by home health agencies in urban and rural areas. Functional improvement scores varied by less than 2 percent, and no statistically significant differences in adverse outcomes are apparent. This is a particularly good indication of the effectiveness of rural home health agencies in providing care to rural beneficiaries in light of the challenges explained above.

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[4] Fazzi Associates, "BestWorks Report" (2005, 2006).

[5] J.P. Sutton, "Patterns of Post-acute Utilization in Rural and Urban Communities: Home Health, Skilled Nursing, and Inpatient Medical Rehabilitation," NORC Walsh Center for Rural Health Analysis (March 2005), *available at http://www.norc.org/NR/rdonlyres/3329577F-87E4-4C4A-BEBE-1D6E66B7C4DD/0/WalshCtr2005_PAcuteU.pdf.*

[6] J.P. Sutton, "Home Health Payment Reform: Trends in the Supply of Rural Agencies and Availability of Home-Based Skilled Services," NORC Walsh Center for Rural Health Analysis (March 2005), *available at www.norc.org/NR/rdonlyres/51442860-0B0F-4F45-A76B-0C3B093FBCFD/0/WalshCtr2005_NORCMarchCX2.pdf.*

The effectiveness of rural home health care, in spite of the numerous obstacles to service provision, is further attested to by Dr. Gary Wiltz, a board certified internist and CEO/Medical Director of the Teche Action Clinic in rural Louisiana. Dr. Wiltz writes:

> *Caring for patients in a rural community presents many challenges, chief among which are lack of transportation, high poverty, low educational attainment and lack of resources available in an urban setting. The patients served by our community health center are truly the sickest of the sick. They suffer from debilitating chronic diseases and co-morbidities impairing functional status. Many of our elderly patients cannot independently obtain health care without assistance. Utilization of home health services results in improved health care outcomes for our patients. Length of hospital stays are decreased when we can provide in-home services, the emergency room visits are decreased when a Plan of Care can be implemented in the home which monitors the patients' health status preventing exacerbations requiring medical intervention, nursing home placement is prolonged or prevented, and overall better disease management especially as it relates to diabetes, hypertension, and heart disease (congestive heart failure).*

Rural beneficiaries' comments about their home health providers also reveal a high degree of satisfaction with—and a strong dependence on—this type of care. As rural beneficiaries' primary providers, home health nurses spend extra time completing assessments, answering patients' questions about their treatments and conditions, and forming relationships with patients. These patients and their families often thank their home care providers for being, among other things, *"very thorough," "[available to] help no matter the time," "very helpful, courteous, and dependable," "prompt," "willing to find out answers for difficult questions,"* and *"comforting."*—Louisiana. Beneficiaries and their families rely on their home health nurses to meet not only their physical needs, but also their emotional, social, and often spiritual needs, frequently coming to view their home health nurses as *"part of the family."*—A.J., Mississippi

However, positive trends like this cannot continue if the current proposed rule, discussed in more detail below, is fully implemented.

VI. THE PROBLEM: THE PROPOSED RULE AND ITS IMPACTS

A. Basics

The proposed rule includes sweeping structural and functional changes to the home health prospective payment system, including:

- A 2008 base payment rate of $2,300 per episode with a negative adjustment for provider coding behavior of 2.75 percent each year for the next 3 years;
- The introduction of 153 home health resource group models based on 4 equations;
- New limitations on rehabilitation therapy access, including a three-threshold model using payment increase trigger points of 6, 14, and 20 visits; and
- Continued application of the pre-floor, pre-reclassified hospital wage index for wage-indexing home health payments, and an increase in the labor-related share of the base payment from 76.775 percent to 77.082 percent.[7]

B. A Disproportionate Impact on Rural Providers

CMS' analysis of the impact of the changes to the home health prospective payment system indicates an overall negative change for rural home health agencies of 0.5 percent and a positive change for urban home health agencies of 1.26 percent. However, CMS data also indicate that the impact on rural proprietary freestanding agencies will be, approximately, a 4.87 percent reduction in reimbursement to these rural agencies as opposed to a negative 1.64 percent impact for their urban counterparts.[8]

Rural providers and industry consultants are still evaluating the effect of the proposed changes on rural providers, but several preliminary reviews of the impact of the proposed rule using 2006 data indicate that the actual impact of the proposed rule on home health reimbursement will be substantially more significant than what is stated by CMS in its regulatory flexibility analysis. Rural wage indices used by CMS are significantly lower than those applied to urban providers, so the actual losses experienced by rural providers will be still greater. Nonetheless, these initial results indicate that rural home health agencies will experience substantially greater losses than the 0.5 percent estimated by CMS in the proposed rule.

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[7] 72 *Fed. Reg.* 25356 (May 4, 2007).
[8] *Id.* at 25456–25457.

Additional analyses of the data and the effects of the proposed rule are ongoing. But the clearly disproportionate impact on rural providers—an impact exceeding CMS' own estimates—makes it imperative that rural agencies obtain immediate help with covering their costs. Reauthorizing the rural add-on is the single most effective means of doing so.

VII. THE SOLUTION—REAUTHORIZATION OF THE RURAL ADD-ON

A. Background

Congress has historically used the rural add-on policy as a means to level the reimbursement playing field for home health agencies that treat rural beneficiaries. Three times in recent history, through the authorization and reauthorizations of the rural add-on, Congress has taken affirmative steps to ensure that strong, high-quality home health care providers are available to serve rural beneficiaries:

- Congress enacted a 10 percent add-on for rural home health between April 1, 2001 and March 31, 2003 as part of the Benefits Improvement and Protection Act of 2000 (BIPA).
- The BIPA 10 percent add-on lapsed for twelve months, but Congress enacted a 5 percent add-on for one year between April 2004 and March 2005 in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
- In February 2006, Congress extended the add-on for an additional year in the Deficit Reduction Act of 2005 (DRA).

The add-on lapsed in 2007, yet the policy rationale for it has not.

B. Legislative History Reflective of Congress' Longtime Concerns

Since 2001, Congress has been sensitive to the challenges rural home health care providers face. The hearing records of Congressional committees are replete with studies and detailed discussions of discrepancies between urban and rural home health costs, net reimbursement values, and differences in clinical care—none of which have changed materially since the add-on was first authorized in 2001. The Medicare Payment Advisory Commission (MedPAC) also supported the add-on, indicating that rural agencies' travel costs are higher than urban agencies' costs and that rural agencies face a cost disadvantage because they have a low volume of services and cannot spread fixed costs over a large number of episodes.[9]

C. Bipartisan Support

The rural add-on has garnered strong bipartisan support throughout its authorization and reauthorizations. In 2003, 57 Senators, led by Senators Susan Collins (R–ME) and Russ Feingold (D–WI), sent a letter to Congressional authorizers and party leaders promoting the add-on to ensure rural access.[10] In 2005, Senators Collins and Feingold introduced legislation to extend the additional payment for home health services in rural areas. The Senators continued to identify as much as a 12 to 15 percent difference in costs to rural home health providers "because of the extra travel time required to cover long distances between patients, higher transportation expenses, and other factors," and they recognized that without the add-on, "agencies may be forced to make decisions to simply not accept rural patients with greater care needs."[11] Senators Collins and Olympia Snowe (R–ME) provided additional data in support of the add-on in a letter to the Senate Finance Committee later that year.[12]

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[9] Glenn Hackbarth, "Hearing on Rural Health Care in Medicare," Hearing before the Subcommittee on Health of the House Committee on Ways and Means (June 12, 2001), *available at* http://waysandmeans.house.gov/legacy.asp?file=legacy/health/107cong/6-12-01/6-12hack.htm.

[10] "Collins & Feingold Lead Effort for Affordable and Comprehensive Home Health Care: 57 Senators Support Elimination of Co-Payments and Changes for Rural Equity" (September 30, 2003), *available at* http://collins.senate.gov/public/continue.cfm?FuseAction=PressRoom.PressReleases&ContentRecord_id=4F3AED3F-802A-23AD-4F7B-A7E4DF562251&CFID=33919502&CFTOKEN=13706486. *See also* Medicare Modernization and Prescription Drug Act of 2002, H. Rep. No. 107–539(I) (2002).

[11] "Senators Collins and Feingold Introduce Rural Home Health Legislation" (February 7, 2005), *available at* http://collins.senate.gov/public/continue.cfm?FuseAction=PressRoom.PressReleases&ContentRecord_id=4F3AC8DE-802A-23AD-4F14-4E1C0663C092&CFID=33919502&CFTOKEN=13706486.

[12] Letter from Sen. Olympia J. Snowe and Sen. Susan Collins to Sen. Charles Grassley and Sen. Max Baucus (December 15, 2005), *available at* http://collins.senate.gov/public/continue.cfm?FuseAction=PressRoom.PressReleases&ContentRecord_id=B092F310-802A-23AD-4581-699286022FDC&CFID=33919502&CFTOKEN=13706486.

VIII. CALL TO ACTION: REAUTHORIZATION OF THE RURAL ADD-ON IN 2008

Rural home health agencies stand in a precarious financial situation. With several sources of extra costs—including increased patient acuity and structural issues associated with rural home health care—and inadequate Medicare reimbursements, rural home health agencies will not be able to continue current service levels without assistance from Congress.

Over the years, rural home health agencies' margins have regularly fallen below urban agencies' margins. A recent MedPAC analysis of 2005 cost report data indicates that freestanding rural agencies face margins that are, on average, 2.8 percent lower than urban agencies' margins.[13] Moreover, approximately 20 percent of all home health agencies had negative margins in 2005, and about 60 percent of hospital-based and 20 percent of freestanding home health agencies lose money providing care to Medicare beneficiaries.[14] While it should be noted that national average margins can be misleading because of the wide variation in home health agency margins, rural home health agencies have the lowest margins in every study reviewed.

National benchmarking data from the Fazzi Associates indicate that home health agencies have a one percent profit margin overall, when all payers and service lines offered by agencies are considered. The benchmark data indicate that urban home health agencies have Medicare profit margins of 11.6 percent and that rural agencies average Medicare margins of 10.5 percent. However, rural agencies had been receiving the 5 percent rural add-on payment during the review period, so the real Medicare margin for rural home health agencies was 5.5 percent, or about one-half of the margins of urban agencies.[15]

Unsurprisingly, removal of the rural add-on would significantly affect rural home health agencies' margins and corresponding ability to serve rural beneficiaries. Between April 1, 2003 and March 31, 2004—the period during which the rural add-on was not in effect—several service areas were reduced and some agencies were forced to turn away resource-intensive patients.[16] Moreover, just before the most recent expiration of the rural add-on in December 2006, a higher percentage of rural than urban states reported service by only one home health agency or by no home health agencies at all.[17] Rural access thus remains a serious problem that will only be worsened if Congress fails to reauthorize the rural add-on.

IX. REINSTATE AND MAKE PERMANENT THE 10 PERCENT ADD-ON

Because ensuring beneficiary access to medically necessary care is one of the Medicare program's central purposes, the threat to rural beneficiary access to home health services should be a primary concern as Congress evaluates the health care system this year in light of CMS' proposed changes. The advent of the substantial structural and functional changes in the Medicare prospective payment system for home health agencies as proposed by CMS makes it imperative that Congress act quickly to reinstate and make permanent a 10 percent rural add-on to avoid additional problems with access to care by rural beneficiaries.

Importantly, policy support for the rural add-on at its inception in 2001 and during subsequent reauthorizations remains in force today. Concerns about the effects of inadequate reimbursements on rural access and on small businesses, as well as proper recognition of the high costs of rural home health agencies and the relative efficiencies of home health care compared to institutional settings, all demand reauthorization of the rural add-on.

The rural home health care provider community has demonstrated remarkable resiliency in adapting to continuing changes in reimbursement over time, but this trend cannot last indefinitely. Essential support in the form of a reauthorized and permanent add-on for rural home health care providers is urgently needed.

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[13] MedPAC, "Report to Congress" (March 2007), 194, 195.
[14] *Id.*
[15] Fazzi Associates, "BestWorks Report" (2005, 2006).
[16] NAHC, "Maintain the Add-on," *supra* note 1; NAHC, "Preserve Access," *supra* note 1.
[17] MedPAC, "Report to Congress" (March 2007), 190.

Without the help of home health, I would be in a nursing home. I have received excellent service that has allowed me to stay in my home, so that I may have the quality of life that is satisfying to me. The thought of losing this service is frightening and would be devastating to me. I plead with you not to cut these services. Please reconsider any changes that limit funding and availability of home care services.— N.E., Arkansas

Statement of Visiting Nurse Associations of America, Boston, Massachusetts

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to present written testimony for the Subcommittee's hearing on "Payments to Certain Medicare Fee-for-Service Providers." As President and Chief Executive Officer of the Visiting Nurse Associations of America (VNAA), the national membership association for non-profit and community-based Visiting Nurse Agencies (VNAs), I speak on behalf of our voluntary Board of Directors and the association's membership.

At the outset, I would like to commend you and Subcommittee Members for your leadership in engaging the health care provider community in reforming Medicare fee-for-service policies with the goal of ensuring that Medicare pays efficiently and appropriately for quality care. We agree with you that Medicare payment policies should be revisited frequently to not only protect the solvency of the Medicare Trust Fund and ensure high quality care for beneficiaries, but also because health care and demographics in the United States are evolving daily. The rapid rate at which American citizens are currently accessing Medicare-covered services will only increase as the baby boom generation approaches retirement. VNAA believes that it is essential for national health care policies to reflect this change in demographics by supporting the most efficient and cost-effective forms of health care delivery, including innovative technologies that support consumer choice of care and independent living.

In this testimony, VNAA would like to address three different areas of Medicare home health payment policy that we believe will help the Subcommittee identify reforms to ensure that Medicare pays efficiently and appropriately for quality care to beneficiaries. These areas include: 1) CMS's newly proposed rule for PPS refinements; 2) MedPAC's analysis involving costs and reimbursement for Medicare-covered services; and 3) Preparing for the future by cost-effectively meetings the health care needs of a rapidly aging society.

Briefly, I will make the case in my testimony that: 1) VNAs' mission to serve as the safety net for the most sick and vulnerable homebound seniors and those with disabilities is currently at risk and would be seriously jeopardized by the Administration's proposed cuts to Medicare home health reimbursement; 2) CMS's policies to account for the true cost of providing home health care in 2007 is outdated and therefore MedPAC's analysis of the adequacy of Medicare home health reimbursement is not based on complete and current cost data; and 3) Home health care has the ability to provide significant savings to the Medicare program if Federal congressional and regulatory policies recognize its cost-efficiency when compared to the costs associated with treating like medical conditions in institutional settings.

About Visiting Nurse Agencies

For over 120 years, VNAs have shared several common goals, including: 1) to provide the highest quality health care to the sickest and the poorest who otherwise would not have access to the health care they need; 2) to help people with chronic illnesses and disabilities to stay within the comfort of their homes by maintaining their health, strength and independence; and 3) to form local partnerships within individual communities to improve the overall public health of those communities.

Today, approximately 400 VNAs provide care to nearly four million individuals each year. While continuing to embrace and fulfill their original common goals, VNAs have evolved to provide the types of highly skilled nursing care that only 20 years ago were rarely provided outside a hospital, such as peritoneal dialysis and intravenous chemotherapy. The tens of thousands of clinicians employed by VNAs are passionate about improving the quality of life of all of their patients, including some of the nation's sickest and poorest individuals. Their expertise is in geriatric care, public health measures such as mass-immunization, infusion therapy, pain management, ventilator care, hospice care, and chronic care management for those with diabetes, congestive heart disease, AIDS, chronic obstructive pulmonary care

and cancer. These basic medical services are supplemented by support services that enable individuals to remain in their homes and communities, including adult day care, Meals on Wheels, personal care services, caregiver education, telehealth monitoring, and nutrition management.

Medicare Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008

The Subcommittee's hearing is particularly timely on the issue of provider payments given the recent publication of several proposed regulations on such payments by the Centers for Medicare and Medicaid Services (CMS). On May 4, the "Medicare Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 Proposed Rule" was published in the Federal Register, 42 CFR Part 484. This proposed rule includes the most significant refinements to the Medicare home health prospective payment system since its implementation in October 2000.

Very generally, it appears that the proposed redistribution of case-mix weights by case-mix categories has incorporated many of VNAA's suggestions to re-balance the system to more fairly reflect costs by case-mix category. However, we are only in the early stages of our analysis and cannot at this point offer definitive recommendations to the Subcommittee regarding this redistribution of payments. We believe that several of the other proposed changes are positive, including the replacement of the "10-therapy visit" threshold with three threshold benchmarks, the increase from 80 to 153 home health resource groups, the elimination of both the "MO175" OASIS variable and the "Significant Change in Condition (SCIC) Adjustment," and the recognition that secondary diagnoses provide a more accurate picture of patient condition.

VNAA is disheartened, though, that CMS inserted a budget-driven, across-the-board 2.75% payment reduction in each of 2008, 2009, and 2010 in order to address what it believes is a provider-driven effort to increase the average case-mix weight. CMS's estimate of the increased case-mix weight between 2000 and 2003 assumes that home health agencies in general had deliberatively "upcoded" the medical and functional status of their patients to achieve higher reimbursement. The estimate dismisses the very real possibility that the demographics of the home health population had changed in the first three years of PPS.

In our experience, the home health profession was generally so confused by the complete overhaul of patient assessment and reimbursement in October 2000 and into the first few years of PPS that "upcoding" would have been highly unlikely. In addition, VNAA has asked CMS for a better understanding of its rationale for why it now assumes that an increase in diagnostic coding following the publication of CMS coding instructions is inappropriate "upcoding" when before CMS had said that this particular increase in diagnostic "upcoding" was a result of nurses' better understanding of diagnostic coding due to the instructions put out by CMS.

For these reasons, VNAA believes that CMS's proposed 2.75% cut in payments in 2008–2010 is based on unreliable assumptions at best about the increase in case-mix weight from 2000 to 2003. The harsh reality is that VNAs in 2004 (year of most recently available data) had an average total operating margin of negative 2.3% accounting for all payer sources. Charity contributions to VNAs brought that average up to 3%. Since that time, costs have only increased—not decreased—because of the stiff competition for clinicians, gas price increases, and purchase of telehealth systems to better manage patient caseloads by thinly stretched clinical staffs.

Last year, the Moran Company produced data for VNAA that demonstrated that 66% of VNA providers have total operating margins of less than 5% and that 39% of VNA providers have negative total operating margins. If CMS includes the combined 8.25% cut in its final rule for PPS refinement, the vast majority of VNAs would be in serious financial jeopardy. The real tragedy though would be the impact that any VNA closures would have on Medicare beneficiaries' access to a safety net home health provider in their community. Following the implementation of the BBA'97 and the devastating Interim Payment System (IPS), 26 VNAs were forced to close their doors. We are concerned what any repetition of the past would have on communities nationwide.

MedPAC's Analysis of Medicare Home Health Reimbursement

The Administration's proposed rule comes on the heels of an equally troubling set of conclusions and recommendations by the Medicare Payment Advisory Commission (MedPAC) regarding home health payments. In its most recent analysis, MedPAC once again concluded that home health agencies' average costs for home health services to Medicare beneficiaries are less than average payments, and there-

fore the annual inflation updates for calendar years 2003–2008 for such services have been viewed as unwarranted.

We believe that MedPAC's annual analyses have been grossly misleading to the Congress for the following reasons:

1) The analyses have not included data from 1,723 home health agencies, or 21% of total home health agencies, that are "provider-based." Therefore, all costs and payments to hospital-based and skilled nursing facility-based home health agencies have been excluded from MedPAC's annual home health margin analysis. Exclusion of these agencies has clearly skewed the average home health margin upward. According to the National Association for Home Care, the average Medicare profit margin of the provider-based agencies in 2004 was less than negative 5.3%. In some states, particularly rural states, provider-based agencies represent the vast majority of existing home health providers and exclusion of those providers' data does not provide a meaningful assessment of beneficiaries' access to home health care.
2) The methodology that MedPAC uses to assess home health agencies' margins is outdated, largely because CMS's policies for what costs are considered "allowable" or "not-allowable" are significantly outdated. MedPAC can only include in its margin analysis the costs that CMS considers "allowable" costs. Yet, the scope of primary "allowable costs" has not been revisited for 10 years. For example, many if not most home health agencies have invested substantial resources in telehealth monitoring to more closely monitor patients at home. The national nursing shortage has made such investments a necessity because telehealth monitors can assist a slim clinical staff in monitoring patients' vital signs and any changes in medical conditions that they may consider alarming.

Telehealth monitors assist nurses in determining which nursing visits are immediately necessary according to the incoming patient data, versus those visits that can be scheduled the following day(s). Telehealth does not replace nursing visits but assists nurses in their management of their patient caseloads, which has been vital in compensating for an average 10% nursing staff vacancy rate during the past few years according to VNAA member surveys.

Data from our agencies demonstrate that early intervention by the clinicians in response to such incoming telehealth data has reduced costly and unnecessary hospitalizations. Yet despite telehealth's clinical value and cost-effectiveness, CMS does not consider telehealth monitoring costs "allowable" for cost reporting purposes because it has concluded that telehealth monitors cannot be considered a replacement for nursing visits. And, because laws that govern home health payments are structured to account only for direct visit costs, telehealth costs therefore cannot be captured, thereby artificially inflating actual home health agency Medicare margins.

Even with the flaws in the CMS and MedPAC approaches to assessing margins, they concede that a significant proportion of agencies face reimbursement challenges that in our view contribute to access problems for Medicare beneficiaries. According to MedPAC, 20% of home health agencies had negative Medicare margins in 2004 (most recent data available) and at least 20% of Medicare beneficiaries had a problem accessing home health care that year.

With such substantial evidence of financial strains on the home care system, VNAs do not think it is wise for the Administration to propose payment cuts or for Congress to freeze home health providers' 2008 update when beneficiaries' access to care is at risk.

Preparing for the Future by Cost-Effectively Meeting the Health Care Needs of a Rapidly Aging Society

VNAA strongly believes that home- and community-based care must be at the center of our health care delivery system to address the inevitable rise in Medicare costs due to the rapid aging of the American population. HHS Secretary Michael Leavitt underscored the cost-effectiveness of such care during his speech to the February 2005 World Health Congress. "Providing the care that lets people live at home if they want is less expensive than providing nursing home care. It frees up resources that can help other people. And obviously, many people are happier living at home," stated Secretary Leavitt.

As the following CMS data illustrate, home health care has the potential to be a huge cost saver to Medicare, Medicaid and private insurance.

Setting	Classification	Length of Stay	Payment (2003 rates)
Inpatient Rehabilitation Facility (IRF)	Case-mix group 804 (lower extremity joint replacement with some functional capabilities)	14 days	$10,828.60 The existence of staphylococcus aureus septicemia, a comorbid condition (ICD–9-CM code 038.11), would place this patient into the tier 2 payment category.
Skilled Nursing Facility (SNF)	Either the very high (RVB) or ultra high (RUB) rehabilitation group	14 days	$4,446.82 for RVB and $6,352.60 for RUB
Long Term Care Hospital (LTCH)	Patient group 238	14 days	$17,671.22
Home Health	High/High/Moderate Group	60-day episode of care	$5,165.26

Source: Statement by CMS, 6/6/2005, Ways and Means Health Subcommittee

To further bolster the notion that home care is a cost effective alternative to institutional care, a June 2005 RAND study, titled "Comparison of Medicare Spending and Outcomes for Beneficiaries with Lower Extremity Joint Replacements," detailed costs and outcomes for hip and knee replacement patients in different post-acute care settings. The report found that total post—acute care payments for inpatient rehabilitation facility (IRF) and skilled nursing facility [SNF] "were $8,023 and $3,578 respectively higher than Medicare payments for patients who were discharged home."

According to RAND, "In general, the results from that model show that in terms of Part A [Medicare] costs, episodes in an IRF or SNF are much more costly for Medicare than for episodes of care among patients going home." *(06/2005 MedPAC Report to Congress)*

The broader medical research community has also documented the cost-effectiveness of home health care. A study published in the December 2005 issue of the Annals of Internal Medicine demonstrated significant savings when patients with similar conditions were treated in their homes instead of hospitals. The average cost of treating patients at home was $5,801 compared to an average cost of treating patients in the hospital of $7,480.

In conclusion, the demand for home health care will continue to grow as both a consumer preference during retirement years and as a result of greater recognition of the cost-savings it produces for payers and consumers. The kinds of highly skilled services that VNAs and other home health agencies provide have enabled millions of Americans to avoid hospital and nursing home stays. By preventing such institutional care, VNAA believes that home health care is a solution to curbing the persistent and continuous rise in national health care costs.

Mr. Chairman and Subcommittee Members, VNAA respectfully urges you to ensure that Medicare beneficiaries continue to have access to home health care by supporting full market basket inflation adjustments in 2008 and in subsequent years as provided under current law and by urging CMS to exclude its proposal to reduce Medicare home health payments by 2.75% in each of 2008, 2009, and 2010.

Thank you again for providing this opportunity to share our concerns and recommendations.

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